DCC-85 COMMONWEALTH OF KENTUCKY N

(R. 11/2018) Cabinet for Health and Family Services

Department for Community Based Services

Division of Child Care

**Approval for Child Care Assistance**

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| --- | --- | --- | --- | --- | --- |
| **Discontinuance Date:** Click or tap here to enter text. | **Benefind Case Number:** | **TWIST Number:** | **Intake ID Number:** | | |
| **Date:** Click or tap to enter a date. | **Initial Approval** | ☐**Recertification** | **Change** | | |
| **APPROVAL INFORMATION** | | | | | |
| **Protective Services Approval** | | | | | |
| **Preventative Services Approval**  \***Co-pay cannot be waived with Preventative Care** | | | | | |
| **Date of Placement with Caregiver:**  Click or tap to enter a date. | | **Child Care Enrollment Start Date:** Click or tap to enter a date. | | | |
| **CO-PAY INFORMATION** | | | | | |
| **Court Ordered Co-pay**  **Amount:** $Click or tap here to enter text. | | | | | |
| **Should Co-pay be waived**  Y**ES**   **NO**  **NOTE: If yes, please document justification in the child’s DCBS PROTECTIVE case plan.** | | | | | |
| **ADULT INFORMATION** | | | | | |
| **FAMILY SIZE** | | | | | |
| **CAREGIVER # 1**  **(Social Security #)** | **(Last Name)** | (**First Name)** | | **(M.I.)** | **(Date of Birth)** |
| **Address:** | | **County:** | | | **Citizenship:** |
| **Telephone:**  **Home** **Work** **Cell** | | | | | |
| **Marital Status:**  **Single**  **Married**  **Divorced**  **Widow**  **Separated** | | **Sex:**  **Male**  **Female** | | **Race/Ethnicity:** | |
| **CAREGIVER #2**  **(Social Security #)** | **(Last Name)** | **(First Name)** | | **(M.I.)** | **(Date of Birth)** |
| **Address:** | | **County:** | | | **Citizenship:** |
| **Telephone:**  **Home**  **Work** **Cell** | | | | | |
| **Marital Status:**  **Single**  **Married**  **Divorced**  **Widow**  **Separated** | | **Sex:**  **Male**  **Female** | | **Race/Ethnicity:** | |
| **If individual is receiving any of the below benefits, please check the appropriate box.**  **SNAP $**   **MEDICAID**  **KTAP** | | | | | |

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| **INCOME** | | | | | | | | | | | | | |
| **Name**  **(Last, First, M.I.)** | | **Employer** | | | **Type of Income**  **(Wages, SSI, etc.)** | | | **Amount** | | | **Received (weekly, biweekly, monthly, semi-monthly or yearly)** | | | |
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| **CHILD INFORMATION** | | | | | | | | | | | | | |
| **Child’s Name**  **(Last, First, M.I.)** | **Child’s SS #** | | **Birth Date**  **(00/00/0000)** | **Sex**  **M/F** | | **Race** | **FD/PD** | | **Days per week** | **Name of School**  **(if attending)** | | **Special Needs** | **Relationship to Caregiver** |
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| **PROVIDER INFORMATION** | |
| **Name:** | |
| **Address:** | **Telephone:** |

**The need for child care has been reviewed and discussed with the caregiver. Child care is needed to accommodate employment, approved activities, and/or the safety of children needing care. Preventative Protective Factor exists.**

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| **Care is needed:**  **Monday**  **Tuesday**  **Wednesday**  **Thursday**  **Friday**  **Saturday**  **Sunday** |
| **Type of care required:**  **Licensed**  **Certified**   **Registered** |

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| **DCBS Worker Name:** |
| **Address:** |
| **City, State and Zip Code:** |
| **DCBS Worker Phone/Email:** |

**DCBS Worker Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FSOS NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **FSOS Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**JUSTIFICATION FOR REFERRAL:** Click or tap here to enter text.

**The DCC-85 is forwarded to CHFS DCBS 85 inbox:** [**DCC85@ky.gov**](mailto:DCC85@ky.gov)

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