

Mental Illness or Intellectual Disability (MI/ID) Supplement Program

Application for Benefits

Privately Owned

Corporately Owned

PCH Name _____

PCH Name _____

Address _____

Address _____

Contact Name: _____

Contact Name: _____

Telephone No. _____

Telephone No. _____

E-mail: _____

E-mail: _____

A. Enter your taxpayer identification number on the appropriate line. For individuals and sole proprietors, this is your Social Security number. For other entities, it is your employer identification number.

Social Security No. - - or Employer ID No. - -

B. Tax Status (check one)

(A) Individual

(B) Sole Proprietorship

(C) Partnership

(D) Estate or Trust

(E) Corporation

(F) Public Service Corp. (PSC)

(G) Governmental or Non-Profit

C. Medical Staff Information

Name	License Number	CMA or KMA Credential

I hereby apply on behalf of the Personal Care Home (PCH) listed above to participate in the MI/ID Supplement Program. The requirements for MI/ID certification, as specified in 921 KAR 2:015, have been read and understood by me. I certify, under penalty of perjury, that information provided to the Department for Community Based Services regarding the eligibility of this PCH to participate in the MI/ID Supplement Program is correct and true to the best of my knowledge. I understand that if I give false information, withhold information, or fail to notify DCBS within 10 working days when the MI/ID population falls below 35% of all occupied personal care beds in the home, I may be subject to prosecution for fraud.

I understand that I have the right to a hearing before an impartial hearing officer, in accordance with 921 KAR 2:055, if I am dissatisfied with any action or inaction of the Department. I can send a request for a hearing in writing to: Cabinet for Health and Family Services, Families and Children Administrative Hearings Branch, 105 Sea Hero Road, Suite 2, Frankfort, KY 40601, or Fax to: (502) 573-1014.

You have the right to receive fair and impartial treatment regardless of your age, sex, race, religious beliefs, political affiliation, national origin or handicap. You may also file your complaint with the Cabinet for Health and Family Services, Office of Human Resource Management, EEO Compliance Branch, 275 East Main Street, 5C-D, Frankfort, Kentucky 40621 or call (502) 564-7770.

Signature (Owner or Operator)

Title

Date