Rev 12/14

SUPPORTS FOR COMMUNITY LIVING
STATEMENT OF SERVICES TO BE PROVIDED

AGENCY NAME: _____

ADDRESS: _____

_____

_____

TELEPHONE: _____

I/WE OF THE: _____
(AGENCY)

wish to provide the following COVERED SERVICES (check all that apply):

1. ☐ Adult Day Health Care
2. ☐ Case Management
3. ☐ Community Access
4. ☐ Community Guide
5. ☐ Consultative Clinical and Therapeutic (Diet/Nutrition)
6. ☐ Consultative Clinical and Therapeutic (Functional Analysis)
7. ☐ Consultative Clinical and Therapeutic (Positive Behavior Supports)
8. ☐ Consultative Clinical and Therapeutic (Psychological Services)
9. ☐ Day Training
10. ☐ Occupational Therapy
11. ☐ Person Centered Coaching
12. ☐ Personal Assistance
13. ☐ Physical Therapy
14. ☐ Positive Behavior Supports
15. ☐ Residential Level I (Staffed Residence; Technology Assisted; Group Home)
16. ☐ Residential Level II (Adult Foster Care; Family Home Provider; Participant's Own Home)
17. ☐ Respite
18. ☐ Speech Therapy
19. ☐ Supported Employment

Please return form to:
Kentucky Medicaid
P.O. Box 2110
Frankfort, KY 40602-2110

CLEAR FORM