Home and Community Based Waiver
Statement of Services Form

Agency Name: _____

Address: _____

_____

Telephone: _____

HCW Waiver Contact Person: _____

HCB Waiver Contact Person Email: _____

Agency Days and Hours of Operation: _____

Counties to be served: _____

** If services vary per county, submit a separate Statement of Services Form for each county.

Our agency wishes to provide the following HCB Waiver covered services (check all that apply):

☐ Case Management (traditional)

And/OR

☐ Adult Day Health

Does your center provide transportation? ☐Yes ☐ No

☐ Goods and Services

☐ Non-Specialized Respite (PDS)

☐ PDS Coordination

☐ Home Delivered Meals

☐ Attendant Care : If providing Attendant Care, will your Attendant Care provider be able/allowed to transport HCB recipient? ☐ Yes ☐ No

☐ Specialized Respite ☐ Home Community Supports (PDS)

☐ Environmental & Minor Home Adaptations

☐ List any exclusions your agency may have in providing a HCB waiver service. (age, transportation, operating hours)

_____

_____

☐ List any specialty services your agency may have in providing a HCB waiver service. (language, interpreters, Alzheimer's)

_____

_____

Name_____

Title: _____ Date:_____

Return form via mail:

Department for Aging and Independent Living
Attention: Amy Moore
275 E. Main Street 3E-E
Frankfort, KY 40621
FAX: (502) 564-4595

Or via email:
dailhcb@ky.gov