KW-32
(R. 09/22[~~12/15~~])
921 KAR 2:017

COMMONWEALTH OF KENTUCKY
Cabinet for Health and Family Services
Department for Community Based Services
Division of Family Support
Phone: 855-306-8959 Fax: 502-573-2007

AUTHORIZATION NUMBER

AUTHORIZATION FOR SUPPORTIVE SERVICES PAYMENTS

Date: _____

Participant Name: _____ Individual ID: _____
Case Name: _____ Case Number: _____
Worker/Issued by: _____ Telephone: _____

TOTAL COST OF ALL ITEMS AND SERVICES CANNOT EXCEED $_____.
If the total cost of all the items and services listed on this form exceeds $300[~~100~~], the Supervisor or designated individual must authorize the cost.
Signature:_____ Date: _____

TO THE PARTICIPANT: Do **NOT** delay in taking this form to the provider. You have 30 days to use this form. If you do **NOT** get the items or services by _____, this form is no longer valid**.** You will need to return this form to DCBS and get a new one.

TO THE PROVIDER: Please complete each column below for each item or service. Once the item or service is provided, have the participant sign this form. ITEMS/SERVICES MAY NOT BE ADDED OR CHANGED. The items listed below are the only items authorized for purchase. If the individual receives additional items not originally listed, the Agency will **NOT** pay for the additional items.

IMPORTANT: This form is valid through _____. If items/services are not provided by _____ this voucher may not be honored.

DESCRIPTION OF ITEM OR SERVICE TO BE PROVIDED					
Type of Item or Service	Estimated Cost	Date Provided	Quantity	Cost Per Item or Service	Total Cost
				TAX	
				TOTAL	

If you are providing a service, we are required by federal law to collect information on your tax status. **If you do not indicate your tax status, we CANNOT pay you.**
Check your tax status: ☐ Individual ☐ Sole Partnership ☐ Partnership ☐ Estate/Trust ☐ Corporation
☐ Public Service Corporation ☐ Government/non-profit

Federal Tax ID#: _____ Social Security Number if no Federal Tax ID#: _____

Signature of Person Completing this form: _____ Title: _____

Date: _____ Phone Number: _____

Payment for the items/services should be sent to:

Provider Name: _____ Store ID Number: _____

Address: _____

The PARTICIPANT [~~participant~~] MUST sign and date this form below before you return it. Please make a copy for your records.

PLEASE RETURN THIS ORIGINAL FORM WITH RECEIPTS AND/OR INVOICES WITHIN 30 DAYS TO:

_____
_____ Fax: _____

TO THE PARTICIPANT: Please sign this form when you have received the items or services.

I certify I have received the above items or services.

Signature: _____ Date: _____