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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

Date:
Case Number:

STATEMENT OF REQUIRED CARETAKER SERVICES

Case Name:
Individual Name:

To the Health Care Professional:

is receiving assistance from the Department for Community Based Services (DCBS). They have [He/she has] reported the need to care for a family member who lives in the home and is mentally or physically incapable of self-care and no alternative care arrangements are available. Your assistance is needed to determine if the caretaker services provided for are required. Attached is an Informed Consent and Release of Information and records form signed by . Thank you.

How many days per week is ________________________ needed to provide the care? __________________

How long will care be needed? ____

[Can this care be provided by another source such as a home health care worker, Hospice, or a nurse?
☐ Yes ☐ No]

____________________________________	____________________
Printed Name of Health Care Professional	Telephone Number
Signature of Health Care Professional	Date

If you have questions, please contact DCBS at 1-855-306-8959.

Please return this form by to:

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Fax: __________________________