

**ATTENTION TO PERSONS WHO ARE
NOT ELIGIBLE FOR AN
ADMINISTRATIVE HEARING:**

**FOR RESOLUTION OF A MATTER NOT
SUBJECT TO REVIEW THROUGH AN
ADMINISTRATIVE HEARING, YOU
MAY CONTACT THE OFFICE OF THE
OMBUDSMAN AT 1-800-372-2973.**

**IF YOU DO NOT WISH TO SPEAK
WITH THE OFFICE OF THE
OMBUDSMAN, YOU MAY SUBMIT
YOUR GRIEVANCE IN WRITING TO A
SERVICE REGION ADMINISTRATOR
OR DESIGNEE NO LATER THAN 30
DAYS FROM THE DATE OF A
CABINET ACTION TO WHICH YOU
OBJECT.**

**TO REQUEST AN
ADMINISTRATIVE HEARING
FOR APPEAL OF A CABINET
FINDING OF CHILD ABUSE OR
NEGLECT, PLEASE COMPLETE
THIS FORM AND MAIL TO:**

Quality Advancement Branch
275 East Main Street, 2E-O
Frankfort KY 40621

**IF YOU NEED ASSISTANCE WITH
COMPLETION OF THIS FORM, PLEASE
CONTACT THE LOCAL OFFICE AT:**

**A REQUEST FOR AN
ADMINISTRATIVE HEARING
SHALL BE POSTMARKED WITHIN
30 DAYS RECEIPT OF THE
SUBSTANTIATED INVESTIGATION
NOTIFICATION LETTER.**

**IF AVAILABLE, PLEASE SUBMIT A
COPY OF THE SUBSTANTIATED
INVESTIGATION NOTIFICATION
LETTER WITH THIS FORM.**

Request for Appeal of Child Abuse or Neglect Investigative Finding

In Accordance
with 45 CFR 205.10,
42 USC 5106a,
and 922 KAR 1:480

**CABINET FOR HEALTH
AND FAMILY SERVICES**

Department for Community
Based Services
275 East Main Street
Frankfort KY 40621

**FOR V/TDD SERVICES
Call the CHFS Office of the
Ombudsman
Toll Free at 1-800-627-4702**

REQUEST FOR APPEAL OF CHILD ABUSE OR NEGLECT INVESTIGATIVE FINDING

 Name of Person Found by the Cabinet to Have Abused or Neglected a Child (Please print) _____ Date _____

 Street/P.O. Box No. City State Zip Code

 Telephone Number County of Residence

PLEASE STATE IN DETAIL THE NATURE OF THE INVESTIGATIVE FINDING AND PROVIDE THE REASON WHY YOU WISH TO DISPUTE THE CABINET'S FINDING OF CHILD ABUSE OR NEGLECT. (ADDITIONAL PAPER MAY BE USED IF NECESSARY.)

PLEASE IDENTIFY THE DATE THE SUBSTANTIATED INVESTIGATION NOTIFICATION LETTER WAS RECEIVED:

MONTH _____ DAY _____ YEAR _____

PLEASE IDENTIFY EACH CABINET STAFF PERSON INVOLVED WITH THE SUBJECT MATTER OF YOUR APPEAL. (ADDITIONAL PAPER MAY BE USED IF NECESSARY.)

Name:	Title, if known:
Work Address:	
City:	County:

Name:	Title, if known:
Work Address:	
City:	County:

 SIGNATURE OF APPELLANT DATE

 SIGNATURE OF APPELLANT'S COUNSEL, IF APPROPRIATE DATE