KIPDA
Kentuckiana Regional Planning & Development Agency

Kentucky Caregiver - Grandparents Raising Grandchildren Program Application

Thank you for your interest in the Kentucky Caregiver program. In addition to access to resources, this program allows KIPDA to provide a clothing allotment up to $500 worth of eligible items for each grandchild included in the application. Please refer to the list of eligible items and quantity limits. The attached application must be completed and submitted to KIPDA for consideration.

This is not an online application- **This application must be printed and mailed or dropped off to KIPDA to be processed.**

Mail or Drop-Off your application to: KIPDA- Social Services Department c/o Mary Anne Hall 11520 Commonwealth Drive Louisville, KY 40299

If your application is approved, you will be added to the waiting list. Per state guidelines, applications will be considered on a priority basis, with applicants that did not receive services through the program in the previous fiscal year receiving higher priority. **A new complete application must be completed each fiscal year. After priority screening, applicants will be approved based on the date the application was approved.**

You will receive notification via letter when you are eligible and approved to create a shopping list with instructions. No orders will be placed in July & August.

Applicant (Grandparent) Full Name:

Applicant Phone Number:

Applicant Mailing Address:

Grandchild Name

Grandchild Name

Grandchild Name

Grandchild Name

Staff use only:

Grandparent ID:

Date Application Received

DCBS Verification Date

Date Approved

Date Completed

Additional Household Members- Do not list grandparent or grandchildren listed on page 1

First & Last Name	Relationship	Income
First & Last Name	Relationship	Income
First & Last Name	Relationship	Income
First & Last Name	Relationship	Income
First & Last Name	Relationship	Income
First & Last Name	Relationship	Income
First & Last Name	Relationship	Income
First & Last Name	Relationship	Income
First & Last Name	Relationship	Income

Application Document Checklist - Please double check your application!

All Documents must be filled out entirely to be approved. Missing information or documentation will result in delayed processing and possibly the inability to participate in the program.

- ☐ **KIPDA Kentucky Caregiver Program Application (Pages 1-2)**
- ☐ **Kentucky Family Caregiver Program Application Page 1-3.**
- ☐ **Kentucky Family Caregiver Program Application Page 2 for EACH grandchild**
- ☐ **Attestation of Relationship for the Caregiver Program (must be notarized)**
- ☐ **Voter Registration Rights & Declination**
- ☐ **Grandparent Rights & Responsibilities**
- ☐ **Informed Consent & Release of Information and Records**
- ☐ **Income Documentation**

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Attestation of Relationship for the Caregiver Program

This form is to be completed by a **FRIEND, FAMILY MEMBER OR PROFESSIONAL** willing to **confirm** or **ATTEST** on a NOTARIZED statement that you are a grandparent by blood, marriage, or adoption to the grandchild(ren) listed. This form must be returned with the application as required by the Kentucky Department of Aging and Independent Living (DAIL) as of October 2017.

All signatures must be made at the same time as notarization.

I, (friend, family member or professional) _____ can attest that (grandparent/applicant) _____

is the grandparent to: (list ALL grandchildren on the application) by blood, marriage, or adoption

_____

The above individual is also the primary caretaker for the grandchild(ren) listed above which also reside in their home.

I can also attest that the parents to the above grandchild(ren) do not reside in the house with the grandparents and grandchild(ren).

I hereby certify that the above information is true and accurate to the best of my knowledge and belief. I understand that if I intentionally provide inaccurate information, the applicant will be terminated from the Caregivers program, and may be subject to legal penalties from the Department of Aging and Independent Living (DAIL)

Signature of Attestant _____ Date _____

Signature of Applicant (Grandparent) _____ Date _____

Signature of Notary _____ Date _____

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GRANDPARENT RIGHTS AND RESPONSIBLITIES

Please read carefully, as this is a legal document. Initial where indicated to note your understanding. If you have any questions as to the meaning of this form regarding your responsibilities or the consequences of not presenting accurate information, please contact us.

The State Regulations governing the KIPDA Grandparent Raising Grandchildren Program are as follows:

910 KAR 1:260 Kentucky Caregiver Program relates to KRS 199.011 (4), 205.455 (4), 42 U.S. C. 601, 651, 1381, 3030s, 3030s-1. Statutory Authority: 2006 KY. Acts ch. 252, KRS 194A.050 (1) Necessity, function, and conformity: 2006 KY. Acts ch. 252 requires the Cabinet to implement the Kentucky Family Caregiver Program providing assistance, including grants or vouchers, to grandparents who are primary caregivers of their grandchildren.

To be eligible for the KIPDA Grandparents Raising Grandchildren program the following must apply:

Section 2. 910 KAR 1:260	**Initial**
1. Be a Kentucky Resident	_____
2. Be the primary caregiver for a grandchild	_____
3. Be related to the grandchild by birth, marriage or adoption	_____
4. Shall not reside in the same household as the parents of the grandchild	_____
5. **922 KAR 1:030**: Shall not receive a monthly payment of Kinship Care	_____
6. Income shall not exceed 150 percent of Federal Poverty Level	_____

(1)A Grandparent shall apply and/or reapply for the Kentucky Family Caregiver Program each fiscal year. Failure to complete a new application will restrict the use of supplemental assistance for the fiscal year until an updated application is completed and approved. (2)A Grandparent shall provide the District with accurate and verifiable information. (3)A grandparent must immediately notify the district of status changes that are noncompliant with the eligibility requirements. (4)Under no circumstance should the grandparent contact the vendor about the voucher system process. The grandparent's relationship is with KIPDA and KIPDA is responsible for communication with the vendor. (5)If the grandparent seeks an appeal, he/she must adhere to the District appeals process. Every grandparent denied service has the right to appeal. (6) A grandparent must comply with the policies and procedures set forth by the Area Agency on Aging and Independent Living and the District.

_____**Initial**

KRS 194A.505 states, "No person shall, with intent to defraud, knowingly make a false statement or misrepresentation or by other means fail to disclose a material fact used in determining the person's qualification to receive benefits under any assistance program. (2) No person shall, with intent to defraud, fail to report a change in the factors affecting a person's eligibility for benefits." By not disclosing pertinent information as it pertains to the KIPDA Grandparents Raising Grandchildren program you are knowingly committing a fraudulent act. You must provide accurate information about your situation in order to maintain services with the KIPDA Grandparents Raising Grandchildren Program.

_____**Initial**

Signature of Caregiver_____ Date_____

Witness_____ Date_____

DAIL-KFC-1 APPLICATION FOR KENTUCKY FAMILY CAREGIVER SERVICES

Complete all information on this application. (Some questions asked for statistical information)

Grandparent and Household Information:

Name(s) of Grandparent Caregiver(s)

_____ *Social Security#* _____ *Gender* ____

_____ *Social Security#* _____ *Gender* ____

Address _____

City _____, *KY Zip:*_____ *County*_____

Phone: _____ *Resident of KY? Yes* ___ *No* ___ *US Citizen? Yes* ___ *No* ___

Age/DOB _____ _____ *Marital Status* _____ *Race*_____ _____

Number of grandchildren being cared for: _____ *(Give information for each grandchild on next page(s)*

Total Number living in household: _____ *Total Household Income(earned and unearned):*_____

Documentation of Gross (before deductions/taxes) Earned and Unearned Income for all members living in the household: (Please attach a copy of pay stubs, letters, etc to verify all income) Check all that apply

_____ *Federal Tax Form (1040, 1040A, etc.) --*
_____ *W2(s)*
_____ *Employment*
_____ *K-Tap*
____ *Veterans*
_____ *Kinship Care*
_____ *Other: Please list:* _____
_____
_____

____ *Social Security*
____ *SSI*
____ *Social Security Disability Income (SSDI)*
____ *Pension/Retirement*
____ *Dividends, subsidies, etc.*
____ *Child Care Assistance*

Formal Support (programs and agencies that are helping you other than those listed above) Check all that apply.

FRYSC/Family Resource Center ☐ *Comp Car/Mental Health Services* ☐ *First Steps* ☐
IMPACT ☐ *IMPACT Plus* ☐ *Food Stamps* ☐ *Women, Infants & Children (WIC)* ☐
Commission for Children with Special Health Care Needs (CCSHCN) ☐
Early Periodic Screening Diagnosis and Treatment (EPSDT) ☐
Other: _____
_____

Informal support (that offer you help): Check all that apply

Family ___ *Friends* ___ *Neighbors* ___ *Church* ____ *Volunteers/Helpers* ____
Other: _____

KENTUCKY FAMILY CAREGIVER PROGRAM APPLICATION

Grandchild Information (Complete one page per grandchild)

Name of grandchild: _____ *Age/DOB* _____
*SS#*_____ *Gender* _____ *Race* _____

Is the grandparent(s) the full-time primary caregiver for this grandchild? Yes ☐ *No* ☐
How are you related to grandchild? Blood ☐ *Marriage* ☐ *Adoption-*☐*-Date (final)* _____
Does this grandchild reside with you? Yes ☐ *No*☐
Does the parent(s) of this grandchild reside in the home? Yes ☐ *No* ☐
Does this grandchild receive Kentucky Kinship Care funds? Yes☐ *No* ☐
Does this grandchild receive Kentucky Transitional Assistance Program (K-Tap)? Yes☐ *No* ☐
Does this grandchild receive Kentucky Children's Health Insurance Program (KCHIP)? Yes ☐ *No* ☐

Supplemental Services/Needs	***Amount/Vendor (for agency use)***
Clothing for grandchild*: Write in number needed next to each item* *Pants/Shorts ___ Skirt/Dress ___ Shirts/Blouses ___* *Sweaters ___ Underwear ___ Socks ___ Pajamas ___* *Shoes/Boots ___ Coat/Jacket ___ hat/gloves ___*	*Amount:* _____ *Vendor:* _____ *Vendor:* _____ *Vendor:* _____
Personal Care Needs *(write in items)*	*Amount:* *Vendor:* _____ *Vendor:* _____ *Vendor:* _____
Educational Needs *(attach documentation from child's school)* *School Supplies/Equipment (one back pack with school supplies)* _____ _____ _____ *Academic Assistance/Tutoring: Explain type and how often:* _____ _____	*Amount:* _____ *Vendor:* _____ *Vendor:* *Vendor:* _____
Legal Services Pursuant to 910 KAR 1:260 Section 7(4): *Please explain the need (attach document showing cost)*	*Amount:* _____ *Vendor:* _____ *Vendor:* _____
Medical and/or Dental Services: *Please explain/attach verification*	*Amount:* _____ *Vendor:* _____ *Vendor:* _____
Furniture for grandchild such as*: (check the item)* *Bed* ☐ *Crib* ☐ *Toddler Bed* ☐ *Dresser* ☐	*Amount:* _____ *Vendor:* _____ *Vendor:* *Vendor:* _____
Respite *(limited break from care giving): Please explain*	*Amount:* _____ *Vendor:* _____ *Vendor:* _____ *Vendor:* _____

TOTAL FUNDS REQUESTED FOR THIS GRANDCHILD: $_____

KENTUCKY FAMILY CAREGIVER PROGRAM APPLICATION

Authorization and Signature Page

Grandparent: Please read information below then sign and date where it says Grandparent.

I am applying to receive services from the Kentucky Family Caregiver Program.

I understand that within thirty (30) days of verifying eligibility, I will be notified if eligible or not eligible for services. If declared not eligible, I have the right to request a local resolution with the district of residence. If I am dissatisfied with the results of the local resolution, I may request an administrative hearing in accordance with KRS Chapter 13B.

I give permission for the Area Agency on Aging and Independent Living or the Department for Aging and Independent Living or its designated contract agency to verify eligibility which includes contacting the Department of Community Services to confirm benefits being received.

I understand if I am found to be fraudulent in the information I share or in the use of the voucher or grant for this program that I could be prosecuted pursuant to KRS Chapter 514 and shall be permanently prohibited from participating in the Kentucky Family Caregiver Program.

I can expect all information concerning me to be kept confidential in accordance with Open Records Statutes; however, I do understand portions of this information may be shared with appropriate parties for purpose of an Exception Request and on a referral basis as identified above or as required by law.

_____ _____

Grandparent Signature ***Date Signed***

I am requesting an Exception by completing Page 3 of this Application

_____ _____

Grandparent Signature ***Date Signed***

_____ _____

KFCP Staff Signature ***Date Received***

Date Client Notified of Eligibility Status:

Eligible: _____ ***Not Eligible: _____ _____***

By phone: _____ ***by letter: _____***

DAIL-VR-01
(R. 7/11)

COMMONWEALTH OF KENTUCKY
Cabinet for Health and Family Services
Department for Aging and Independent Living

VOTER REGISTRATION RIGHTS AND DECLINATION

_____
(Applicant's Name)

REGISTERING TO VOTE

If you are not registered to vote where you live now, would you like to apply to register to vote? (please check the appropriate box).

☐ YES ☐ NO ☐ ALREADY REGISTERED

IF YOU DO NOT CHECK ONE OF THE BOXES ABOVE, IT WILL BE CONSIDERED THAT YOU HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

_____ _____
(Applicant's Signature) (Date)

If you register to vote or decline to register to vote, this decision and any information regarding the office to which the application was submitted remains confidential and is used only for voter registration purposes.

Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency.

If you would like help filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may complete the application form in private, if you desire.

If you complete a voter registration application form, it will be forwarded to your local county clerk who will assign you a voting precinct. A confirmation notice with your precinct and voting location will be mailed to you by the county clerk. IF YOU DO NOT RECEIVE SUCH NOTICE WITHIN THREE (3) WEEKS, PLEASE CALL YOUR COUNTY CLERK.

If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register, or in applying to register to vote, or your right to choose your own political party or other preference, you may file a complaint by writing or calling the State Board of Elections, 140 Walnut Street, Frankfort KY 40601, phone 1-800-246-1399.

Please note that KRS 116.045(2) requires the clerk to close all registration 28 days prior to any election. If your application is received during this period, you will not be eligible to vote until the next election.

(R. 01/07)

COMMONWEALTH OF KENTUCKY
Cabinet for Health and Family Services
Department for Aging and Independent Living

INFORMED CONSENT AND RELEASE OF INFORMATION AND RECORDS

Name_____ **SSN**_____

I understand to help my family and I get the services we need, the Area Agency on Aging (AAA), Division of Aging (DAS) and the Department for Community Based Services (DCBS) may need to share information and records in order to provide or verify eligibility for these services. By signing this form, I give AAA and DCBS staff permission to share information needed to see if I am eligible for any assistance program. I also give permission for AAA and DCBS to share information and records with one another about services or benefits provided to me and my family.

My consent includes the following information and records (please put your initials beside each checked item that you consent to):

____ Residential Records
____ Kinship
____ Food Stamp Record
____ K-TAP Records
____ Child Support Records
____ Other_____

This consent applies to the following members of my family:

Member Name	SSN	Relationship	Member Name	SSN	Relationship

I understand that:

- This authorization will be in effect for a period of _____ (not to exceed 12 months) from the signature date.
- I may revoke this consent at any time in writing unless action has already been taken based on my consent.
- Signing this form is voluntary, but failing to sign it, or revoking it before the necessary information is obtained, could prevent an accurate or timely response and could result in denial or loss of benefits.
- Information disclosed to DCBS may no longer be protected by the health information privacy provisions of 45 CFR Parts 160 and 164 pursuant to the Health Insurance Portability and Accountability Act (HIPAA).
- Information may be redisclosed by AAA without my consent if authorized by State Law or Federal Laws such as the Privacy Act or 42 CFR Part 2 or to comply with laws regarding mandatory reporting of suspected abuse, neglect or exploitation, or assessment that there is a danger of serious harm to self or others.
- I have received a copy of this form. I may also request a copy of the information retained with it.

Signature _____ Date _____
Grandparent

Signature _____ Date _____
Grandparent

Witness Signature _____ Date _____

Grandparent Eligible and Ineligible Items List with Quantity Limits

Items Allowed	Quantity Allowed	Price Per Item
Pants/Shorts	Multiple	No more than $50 per one item
Shirts/Blouses	Multiple	No more than $50 per one item
Skirts/Dresses	Multiple	No more than $50 per one item
Sweaters/Hoodies	Multiple	No more than $50 per one item
Underwear/Bras/Pajamas	Multiple Pkgs or Pairs	Varied
Socks	Multiple Pkgs or Pairs	Varied
Shoes	2 Pair	$50.00 max per pair
Coats/Jackets	Multiple	Varied
Hats & Gloves	Limit 1 of each	Varied
Backpack	Limit 1	$25.00
Hairbrush/Comb	Limit 1	Varied
Soap/Body Wash	Limit 2	Varied
Shampoo/Conditioner	Limit 2	Varied
Deodorant	Limit 2	Varied
Sheets/Pillowcases/Comforter	1 Set	Varied
Diapers (appropriate to age)	Multiple	Varied
Diaper Wipes (appropriate to age)	10 individual packs or 2 cases	Varied
Total Order not to exceed $500	**Items are reviewed and accepted or deleted from order based on discretion of Coordinator**	**If order totals over $500, the least expense item(s) will be removed to allow for shipping.**
Items NOT Allowed	Please be sure to allow for shipping to be added to your order.	
NO Perfume/Cologne/Body Spray/After Shave		
NO Lotions, Butter, Creams, etc.		
NO Exfoliating Products (gloves, mitts, scrubs, etc.)		
NO Jewelry		
NO Cosmetics/Makeup		
NO Hair Accessories (NO Headbands/NO Barrettes)		
NO Purse/Wallet		
NO Games/Toys/Electronics		
NO purchases for grandparent or anyone else other than the grandchild specified on the order		
NO Swimsuits/Swim Trunks unless needed for physician ordered aquatic therapy.		
Infants/ Toddlers are allowed car seat, high chair, basic swing, or crib	Limit one of any item	Varied