FS-704
(04/17)

COMMONWEALTH OF KENTUCKY
Cabinet for Health and Family Services
Department for Community Based Services
Division of Family Support

Date: _____
Case Number: _____

STATEMENT OF DISABILITY OR INCAPACITY

Applicant Name: _____ Applicant ID: # _____

Dear Healthcare Professional:

The above named individual has applied for or is receiving assistance from this Agency. In order to receive or continue to receive assistance, persons between the ages of 18 and 60 must be employed, registered for employment or certified as disabled or incapacitated.

This individual states that he/she is unable to work and is currently under your care. In order to determine his/her eligibility for assistance, we request that you check the appropriate block below. If you feel that none of the statements are relevant to this person, a "Remarks" section is provided.

A signed DCBS-1, Informed Consent and Release of Information and Records or DCBS-1A Supplement, is attached. This individual is aware that he/she is responsible for any charges for services you provide.

Worker's Name _____

_____
(Street Address)

_____
(City) (State) (ZipCode)

HEALTHCARE PROFESSIONAL'S STATEMENT

In my opinion:

[ ] This patient is temporarily disabled or incapacitated and can return to work on _____
(date)

If data unknown, please explain: _____

[ ] The patient is permanently and totally disabled and will never be gainfully employed

[ ] This patient is not disabled or incapacitated and can be employed.

Remarks: _____

_____

Signature _____ Title: _____

Telephone Number: _____ Date: _____

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office,

or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, DC 20250-9410;
(2) fax: (202) 690-7442; or
(3) email: program.intake@usda.gov.

This institution is an equal opportunity provider.

You may also file your complaint with the Cabinet for Health and Family Services, Office of Human Resource Management, EEO Compliance Branch, 275 E Main St, 5C-D, Frankfort, KY 40621 or call (502) 564-7770 EXT. 4107.

If you have other complaints about your SNAP case, you can call the Ombudsman's Office at 1-800-372-2973 or (TTY) 1-800-627-4702.