



**COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
Office of the Inspector General
Division of Regulated Child Care**

For Official Use Only: Date
Rcvd. By DRCC

Licensed Provider Request for Appeal

Child Care Center Name: _____ License #: _____

Director or Designee's Name: _____

Mailing Address: _____ City: _____ State: _____

Zip Code: _____ Phone Number: _____ Cell Phone Number: _____

I am represented by an attorney: ☐ Yes ☐ No

Attorney's Name: _____

Mailing Address: _____ City: _____ State: _____

Zip Code: _____ Phone Number: _____ Cell Phone Number: _____

I am appealing the following action(s):

- ☐ Civil Penalty
☐ Emergency Suspension
☐ Denial of Licensure
☐ Revocation of License
☐ Revocation of Transportation Services
☐ Other (Please Specify): _____

☐ I understand that by submitting this form, I am requesting an appeal hearing in accordance with KRS 13B.050 and 199.896(7) for the above checked action. I also understand that it is at my discretion as to if I would like to request an Informal Dispute Resolution (IDR) conducted by the Division of Regulated Child Care (DRCC).

I am requesting an IDR in addition to my hearing request: ☐ Yes ☐ No

☐ I understand that by requesting an IDR, my request for a hearing will be held in abeyance until the IDR process is complete. I also understand that once the IDR process is complete, DRCC will submit my hearing request to the Administrative Hearings Branch who will in turn contact me or my attorney listed above.

Date you received notice of action you are appealing: _____

(Attach a copy of any written notice you received relating to this appeal)

This form shall be submitted to DRCC within twenty (20) calendar days of the notice of adverse action.

Appeal Explanation: Please submit a short and concise statement of why you wish to appeal this action:

