9/18

CABINET FOR HEALTH AND FAMILY SERVICES
COMMONWEALTH OF KENTUCKY
275 EAST MAIN STREET, 3E-D
FRANKFORT, KY 40621
DEPARTMENT FOR COMMUNITY BASED SERVICES
DIVISION OF PROTECTION AND PERMANENCY
AN EQUAL OPPORTUNITY EMPLOYER

DCBS Office Address: Date: _____

_____
_____
_____

Circuit Court Clerk of _____ County:

This letter is to verify that _____ (child's name), resides at _____ (current address), is in the custody of the Cabinet for Health and Family Services and has been approved to obtain their **State Identification Card**. The following person is authorized to sign the application for this child:

_____

Name of adult authorized to sign Date

If you have questions regarding this certification please contact:

_____
Child's Social Service Worker

_____
Telephone number

Sincerely,

_____
State Social Service Worker
Cabinet for Health and Family Services
Department for Community Based Services

Required Documentation:

- ☐ Certified birth certificate
- ☐ Original social security card
- ☐ Proof of Residency (this letter acts as proof of residency)
- ☐ State I.D. of Adult Authorized to Sign Application