



**CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR COMMUNITY BASED SERVICES
DIVISION OF PROTECTION AND PERMANENCY**

DCBS Office Address:

Date_____

This letter is to verify that _____ (child's name),
resides at _____, is in the custody of the
Cabinet for Health and Family Services (CHFS), and has been approved to pursue their application for an
**operator's license, motorcycle operator's license, intermediate license, or any instruction permit, in
accordance with KRS 186.450 and KRS 186.470.**

The following person is authorized to sign the application for the child: _____.

Sincerely,

Regional Independent Living Specialist
Cabinet for Health and Family Services
Department for Community Based Services

Service Region Administrator/Designee
Cabinet for Health and Family Services
Department for Community Based Services

Required Documentation:

- ☐ Certified Birth Certificate
- ☐ Social Security Card
- ☐ Proof of Residency (this letter acts as proof of residency)
- ☐ School Compliance Verification Form
- ☐ State I.D. of adult authorized to sign application