



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

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 a **State
Identification Card**.

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

If you have questions regarding this certification, please contact:

Child's social service worker

Telephone number

Sincerely,

State social service worker
Department for Community Based Services

Required Documentation:

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