

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: \_\_\_\_\_

Three horizontal lines for address input.

Circuit Court Clerk of \_\_\_\_\_ County:

This letter is to verify that \_\_\_\_\_ (child's name), resides at \_\_\_\_\_, is in the custody of the Cabinet for Health and Family Services and has been approved to pursue his/her 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 driver's 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,

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

Required Documentation:

- Original or Certified Copy of Birth Certificate
Original 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