



**CABINET FOR HEALTH AND FAMILY SERVICES**

**Matthew G. Bevin**  
Governor

**Cabinet For Health and Family Services**  
DEPARTMENT FOR COMMUNITY BASED SERVICES  
COUNCIL ON ACCREDITATION (COA ACCREDITED)  
CHAFEE INDEPENDENCE PROGRAM  
275 EAST MAIN STREET, 3E-D  
FRANKFORT KY 40621  
502-564-2147

**Adam M. Meier**  
Secretary

TO: TWIST Payments  
THROUGH: Central Office Staff, Chafee Independence Program  
FROM: \_\_\_\_\_  
Independent Living Specialist  
SUBJECT: REQUEST FOR APPROVAL OF SPECIAL EXPENSE  
For: \_\_\_\_\_ DOB: \_\_\_\_\_  
SSN: \_\_\_\_\_ Case #: \_\_\_\_\_

Region of Service: \_\_\_\_\_

Date of Training (s): \_\_\_\_\_

Resource/Vendor Name: \_\_\_\_\_

I am requesting approval for \$ \_\_\_\_\_ for the items specified below. Detailed Explanation / justification follows:

**Completion of State Approved Driver's Education Program**

Total Amount of check: \$ \_\_\_\_\_

Reviewed: \_\_\_\_\_ Date: \_\_\_\_\_  
Central Office Staff, Chafee Independence Program

Checks will be mailed to the Independent Living Specialist (Name and Address Below)

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

