

## KENTUCKY IGNITION INTERLOCK PROGRAM AFFORDABILITY APPLICATION

**INSTRUCTIONS:** If you are monetarily indigent and plan to participate in the Kentucky Ignition Interlock Program (KIIP), complete this form for possible fee reduction.

Applications without submission of the required documents will be denied. Attachments will not be returned.

<b>Return the completed form and required documents to:</b> Kentucky Transportation Cabinet Department of Vehicle Regulation/DDL 200 Mero Street, 2 <sup>nd</sup> Floor IID Frankfort, KY 40622	<b>Or submit the completed form and required documents to:</b> Email: <a href="mailto:KIIP@ky.gov">KIIP@ky.gov</a> Fax: 844.535.7209
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### SECTION 1: APPLICANT INFORMATION

<b>FULL LEGAL NAME</b> ( <i>Print.</i> )	<b>DATE OF BIRTH</b> ( <i>mm/dd/yyyy</i> )	<b>DRIVER LICENSE #</b>	
<b>STREET ADDRESS</b>	<b>CITY</b>	<b>STATE</b>	<b>ZIP</b>
<b>MAILING ADDRESS</b> ( <i>if different from street address</i> )	<b>CITY</b>	<b>STATE</b>	<b>ZIP</b>
<b>PHONE</b>	<b>EMAIL</b>		

*If applicant is claimed as a dependent by a parent or other family member, provide the full legal name of person who claims applicant as a dependent.* \_\_\_\_\_

### SECTION 2: ELIGIBILITY INFORMATION & APPLICANT SIGNATURE

Fees are established in [KRS 189A.340\(7\)\(2\)](#), and fee reduction is based on the Federal Poverty Guidelines found online at: <https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines>

**ASSISTANCE ELIGIBILITY:** (*Check all that apply. Provide proof for each selection, if applicable. Attached proof must reflect current benefits.*)

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|--|--|
| <input type="checkbox"/> Cabinet for Health and Family Services benefits (Medicaid, SNAP, KTAP, CCAP, KI-HIPP-benefits/award letter) | <input type="checkbox"/> VA benefits (benefits/award letter, unemployment) |
| <input type="checkbox"/> Medicare (welcome packet letter or benefits/award letter)   | <input type="checkbox"/> Self-Employed (notarized statement of income)     |
| <input type="checkbox"/> Refugee resettlement benefits (benefits/award letter)   |  |

**INCOME VERIFICATION:** (*Submit proof of income, such as most recent 3 month's paystubs or most recent federal tax return with 1099's or W2's. If you have no income or do not have proof of income, attach a signed notarized statement explaining this.*)

- How many live in your household (including yourself)? .....
- Total monthly household income .....\$
- Contributions from any family member or other person(s) living in the household who is helping with your basic living costs .....\$
- Other income .....\$
- Pensions, annuities, and/or social security .....\$

*I certify under penalty of revocation of participation in the indigent program under the laws of the Commonwealth of Kentucky that the foregoing is true and correct. I understand that indigent status will NOT exceed the maximum suspension time and that I must recertify this application annually.*

<b>APPLICANT NAME</b> ( <i>Print</i> )	<b>APPLICANT SIGNATURE</b>	<b>DATE</b>
<b>KYTC USE ONLY:</b>		
Application approved: <input type="checkbox"/> Yes <input type="checkbox"/> No    Percentage approved: <input type="checkbox"/> 100 % <input type="checkbox"/> 75 % <input type="checkbox"/> 50 % <input type="checkbox"/> 25 %		
Date of decision: _____		Reviewed by: _____