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Attachments will not be returned. | | | | | | | | | | | | | | | | | | | | | | | | | **Return the completed form and required documents to:**  Kentucky Transportation Cabinet  Department of Vehicle Regulation/DDL  200 Mero Street, 2nd Floor IID  Frankfort, KY 40622 | | | | | | | | | | **Or submit the completed form and required documents to:** | | | | | | | | | | | | | | | **Email:** [**KIIP@ky.gov**](mailto:KIIP@ky.gov)  **Fax:** 844.535.7209 | | | | | | | | | | | | | | | **SECTION 1: APPLICANT INFORMATION** | | | | | | | | | | | | | | | | | | | | | | | | | **FULL LEGAL NAME** (*Print.*) | | | | | | | | | **DATE OF BIRTH** (*mm/dd/yyyy*) | | | | | | **DRIVER LICENSE #** | | | | | | | | | | **STREET ADDRESS** | | | | | | | | | **CITY** | | | | | | **STATE** | | | **ZIP** | | | | | | | **MAILING ADDRESS** (*if different from street address*) | | | | | | | | | **CITY** | | | | | | **STATE** | | | **ZIP** | | | | | | | **PHONE** | | | | | | | | | **EMAIL** | | | | | | | | | | | | | | | | ***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](https://apps.legislature.ky.gov/law/statutes/statute.aspx?id=49873)(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.)* | | | | | | | | | | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | | | | | | | | | | |  | | | Cabinet for Health and Family Services benefits (Medicaid, SNAP, KTAP, CCAP, KI-HIPP-benefits/award letter) | | | | | | | | | | | | | | | | | | | | | |  | | | Medicare (welcome packet letter or benefits/award letter) | | | | | | |  |  |  | VA benefits (benefits/award letter, unemployment) Unemployment | | | | | | | | | | | |  | | | Refugee resettlement benefits (benefits/award letter) | | | | | | |  |  |  | Self-Employed (notarized statement of income) | | | | | | | | | | | | **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.*) | | | | | | | | | | | | | | | | | | | | | | | | | **1.** | How many live in your household (including yourself)? . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . | | | | | | | | | | | | | | |  | | | | | | |  | | **2.** | Total monthly household income . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .**$** | | | | | | | | | | | | | | |  | | | | | | |  | | **3.** | Contributions from any family member or other person(s) living in the household who is helping with your basic living costs . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . **$** | | | | | | | | | | | | | | |  | | | | | | |  | | **4.** | Other income . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . .**$** | | | | | | | | | | | | | | |  | | | | | | |  | | **5.** | Pensions, annuities, and/or social security . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . **$** | | | | | | | | | | | | | | |  | | | | | | |  | |  |  | | | | | | | | | | | | | | |  | | | | | | |  | | *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.* | | | | | | | | | | | | | | | | | | | | | | | | |  | |  | | | | |  |  | | | | | | | | |  | |  |  | |  | | |  | | **APPLICANT NAME (*Print*)** | | | | |  | **APPLICANT SIGNATURE** | | | | | | | | |  | |  | **DATE** | |  | | | **KYTC USE ONLY:** | | | | | | | | | | | | | | | | | | | | | | | | | Recertification approved:  Yes  No | | | | | | Percentage approved:  100 %  75 %  50 %  25 % | | | | | | | | | | | | | | | |  | | | Date of decision: | | | |  | | | | Reviewed by: | | | | | |  | | | | | | | |  | | |  | | | |  | | |  |  | | | | | |  | | | | | | | |  | | |