DPP-333, 922 KAR 1:450 (Rev. 03/31/2008)

TUITION WAIVER FOR FOSTER AND ADOPTED FOR CHILDREN

SECTION 1 — APPLICANT INFORMATION

FULL NAME: *(please print)*		
STREET:	CITY:	
STATE: ZIP:	COUNTY:	
E-MAIL ADDRESS:		
PHONE NUMBER:	DATE OF BIRTH:	SSN:
FOSTER OR ADOPTIVE PARENTS' FULL NAMES (Include Middle &/or Maiden Name):		
DATE OF HIGH SCHOOL GRADUATION OR GED CERTIFICATE:		
DATE OF ANTICIPATED ENTRY TO INSTITUTION:		

Student requests waiver under the following conditions *(check all that apply):*

- ☐ Is currently committed and placed in foster care by the Cabinet for Health and Family Services.
- ☐ Is in an Independent Living Program funded by the Cabinet for Health and Family Services.
- ☐ Was in the permanent legal custody of the Cabinet for Health and Family Services prior to being adopted and the family received state-funded adoption assistance.
- ☐ Was in the legal custody of the Cabinet for Health and Family Services on his or her eighteenth (18th) birthday.

Has applicant previously applied and received a Tuition Waiver for Foster and Adopted Children?
_____ Yes _____ No If "Yes", when? _____

Release of this information shall not constitute a breach of confidentiality required by KRS 199.570 and 620.050. I agree to the release of the above-referenced information to the post-secondary institution.

☐ I agree to provide the Cabinet for Health and Family Services the date of my graduation.

_____ _____
Student or Guardian Signature Date

SECTION 2 — PUBLIC POST-SECONDARY INSTITUTION REQUEST

I am requesting that the information in Section 1 be verified to determine the eligibility of the above named applicant.

_____ _____
Name of Institution Address of Institution

_____ _____ _____
Phone number Date Institution Contact Person (Please print)

SECTION 3 – TUITION WAIVER VERIFICATION

CABINET FOR HEALTH AND FAMILY SERVICES
ATTN: KEITH JONES OR SHELLEY BROWN

ATTN: Tuition Waiver
275 East Main Street Mail Drop 3 E-D
Frankfort, KY 40621
502-564-2147 or 800-232-5437
(FAX: 502-564-5995)

____ **ELIGIBLE** ____ **INELIGIBLE**

If ineligible, you have the right to appeal in accordance with 922 KAR 1:320.

_____ _____
SIGNATURE OF AUTHORIZED CABINET PERSONNEL DATE