

DEPARTMENT OF TRANSITIONAL ASSISTANCE
Signed Authorization for Social Services Organization or Legal Advocate
to Access DTA Client Case Information

REQUEST FOR ACCESS TO CLIENT RECORD OF: _____
(Client's Full Name)

1. Client Information:

Date of Birth ___ / ___ / ___ Address: _____

SS#: _____

Number of Dependent children: _____

2. I hereby authorize _____ (name of organization and address) to have access to my DTA record and discuss my application or eligibility for DTA benefits with a DTA case manager, supervisor or other employee.

3. I hereby certify that I am the client named above.

Date

(Client's Signature)

For Department Use Only

4. I find that the information in item 1 and the signature in item 3 match the information and signature in the client record.

Name of Dept. Employee (Print)

Date