

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



Commonwealth of Massachusetts
Department of Transitional Assistance

Request for Authorized Representative- Authorized
Agency-Authorized Payee

Office Name _____

_____/_____/_____
Date

Office Address _____

Food Stamp Benefits

I authorize _____ to act as my representative for application
Print Name of Authorized Person
and recertification of food stamp benefits only.

I authorize _____ to act as my representative for transaction
Print Name of Authorized Person
of food stamps benefits only.

I authorize _____ to act as my representative for transaction
Print Agency Name
of food stamps benefits only. I _____ am authorized by the above
Print Agency Representative Name
agency to receive the EBT card that will be used for transaction of food stamp benefits only.

Administrative Office Address

I authorize _____ to act as my representative for **both**
Print Name of Authorized Person
application and recertification of food stamp benefits and transaction of food stamp benefits.

Print Recipient's Name

Recipient's Telephone

Recipient's Signature

Recipient's SSN

Authorized Representative's Signature or Agency
Representative's Signature (for authorization only)

Authorized Representative's SSN or Agency's FEIN

Authorized Representative's Date of Birth

Worker's Name

Worker's Telephone

Cash Benefits

I authorize _____ to act as my authorized payee for all
cash transactions on my behalf.
Print Name of Authorized Payee

Print Recipient's Name

Recipient's Telephone

Recipient's Signature

Recipient's SSN

Authorized Payee's Signature (for authorization only)

Authorized Payee's SSN

Authorized Payee's Date of Birth

Worker's Name

Worker's Telephone

YOUR RESPONSIBILITY

You must call 1-800-997-2555 to stop the person(s) you chose from being your Authorized Representative and/or Payee. If you do not call to stop the person(s) from being your Authorized Representative and/or Payee, he or she will continue to have access to your benefits even if your case closes and reopens at a later date.