Attachment G

DEPARTMENT OF TRANSITIONAL ASSISTANCE
Written Consent to Access DTA Client Case Information

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

1. Client Information:

   Date of Birth __/__/__ Address: _____

   _____

   Last 4 digits of SS#: __ __ __ __ or DTA "Agency ID" number: _____

   Number of Dependent children: _____

2. I hereby authorize _____
   (organization's name and city/town) to have access to my DTA SNAP or cash assistance case record, including any electronic records. I authorize this organization to discuss my application or benefits with a DTA case manager, supervisor, director or other DTA employee. This form is valid for 12 months unless I have stated otherwise on this form or in other communication.

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