

## APPLICANT/RECIPIENT AUTHORIZATION FOR RELEASE OF INFORMATION

NAME AND ADDRESS OF COMPANY	JCDJFS USE ONLY
	CASE NAME:
	CASE NUMBER:
	JCDJFS REPRESENTATIVE:
	UNIQUE IDENTIFIER:
	DATE OF THIS REQUEST:

I AGREE THAT THE PERSON NAMED ABOVE MAY RELEASE TO THE JEFFERSON COUNTY DEPARTMENT OF JOB AND FAMILY SERVICES THE FOLLOWING INFORMATION: \_\_\_\_\_

THIS INFORMATION WILL BE USED TO:

DETERMINE ELIGIBILITY FOR:    OWF (ADC)    MEDICAID    GENERAL RELIEF    FOOD STAMPS

OTHER USE:   SPECIFY: \_\_\_\_\_

I AM AWARE OF MY RESPONSIBILITIES TO REPORT COMPLETELY AND FULLY ALL FACTS WHICH BEAR UPON MY ELIGIBILITY FOR PUBLIC ASSISTANCE. I REALIZE IF THE REQUESTED INFORMATION REVEALS I HAVE IMPROPERLY REPORTED MY SITUATION, THE INFORMATION MAY BE GIVEN TO THE PROSECUTING ATTORNEY FOR POSSIBLE CIVIL ACTION OR CRIMINAL PROSECUTION.

X   SIGNATURE OF APPLICANT/RECIPIENT	X   DATE
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THIS SPACE IS PROVIDED FOR THE REPLY

(IF APPLICABLE - A COMPUTER PRINTOUT TO DOCUMENT THE INFORMATION REQUESTED IS ACCEPTABLE)

NAME OF INSURED	POLICY NUMBER	BEGIN DATE	POLICY TYPE		FACE VALUE	CASH VALUE & EFF. DATE	LOAN & DATE IF ANY	POLICY OWNER
			<input type="checkbox"/>	WHOLE LIFE TERM				
			<input type="checkbox"/>	WHOLE LIFE TERM				
			<input type="checkbox"/>	WHOLE LIFE TERM				
			<input type="checkbox"/>	WHOLE LIFE TERM				
			<input type="checkbox"/>	WHOLE LIFE TERM				
			<input type="checkbox"/>	WHOLE LIFE TERM				
			<input type="checkbox"/>	WHOLE LIFE TERM				

SIGNATURE & TITLE OF PERSON SUPPLYING INFORMATION	PHONE NUMBER	FAX NUMBER	DATE
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