Clear Form

Minnesota Department of **Human Services**

DHS-2952-ENG 9-14

Clear Form

Authorization for Release of Information About Residence and Shelter Expenses

Date:

Case number:

To:

Worker name:

Agency name:

Agency address:

City, state, zip code:

Worker phone: Fax:

We need to verify the residence and shelter expenses of the person(s) listed below:

Tenant's name:

Address/apt. no.:

City/county/state/zip code:

Please provide the information requested **on the back of this form** and sign and date the back of the form where indicated. Below is a signed authorization to release this information to the agency shown above. Thank you for your cooperation.

Authorization for Release of Information

Giving Permission: I give permission for the person/organization above to release the requested information to the above agency. This information is used to figure my eligibility for public assistance and/or services.

Consequences: State and Federal privacy laws protect my records. I know:

- Why I am being asked to release this information
- I do not have to consent to this authorization, but it may affect my benefits or services if I do not give my consent
- That, generally, I must give my written consent for this person/agency to give out this information, but if I do not consent, the information will not be released unless the law otherwise allows it
- I may stop this authorization with a written notice at any time, but this written notice will not affect information the agency has already requested
- The person or agency who gets my information may be able to pass it on to others
- If my information is passed on to others by the Minnesota Department of Human Services, it may no longer be protected by this authorization.

This authorization will end one year from the date I sign it, unless the law allows for a longer period.

CLIENT SIGNATURE	DATE	Original copy for agency Provide copy to client
SIGNATURE OF SPOUSE/GUARDIAN/AUTHORIZED REPRESENTATIVE	DATE	

Over

To Be Completed by Owner, Manager, or Caretaker Only

(Complete all appropriate information and mail or fax to agency address/fax number on first page.)

Note: Completing this form does not guarantee rent payment.

TENANT NAME	CASE NUMBER

Rental Information

Date moved in _____ Number of adults in unit _____ Number of children in unit _____

Total rent for unit $_____ Damage deposit $_____ ☐ Paid ☐ Not paid

Amount of rent **paid by tenant** $_____ per ☐ Week ☐ Month ☐ Other Effective date _____

Is any portion of the rent **paid by rental subsidy**? ☐ Yes ☐ No

If yes, is the subsidy from Public Housing, HUD project properties or Section 8? ☐ Yes ☐ No Amount $_____

Is any portion of the rent **paid by GRH**? ☐ Yes ☐ No

Check (x) which utilities the **tenant** is responsible to pay:

☐ Gas ☐ Electricity ☐ Garbage removal ☐ Water and sewer ☐ Air conditioning ☐ Garage/plug-in

Is Garage or plug-in optional? ☐ Yes ☐ No Amount $_____

☐ Other _____

☐ None

Room and Board

Amount of room and board paid by tenant? $_____ Per ☐ Week ☐ Month Effective date _____

Meals included in room and board? ☐ Breakfast ☐ Lunch ☐ Dinner ☐ No meals included

Caretaking or Other Tenant Responsibilities

Is the rent or room and board reduced by caretaking or other such tenant responsibilities? ☐ Yes ☐ No

If yes, does the tenant receive a paycheck with an amount for rent or room and board deducted? ☐ Yes ☐ No

If the tenant does not receive a paycheck with an amount for rent or room and board deducted, does the tenant have a choice of receiving cash instead of a reduction on rent or room and board? ☐ Yes ☐ No

Amount of room and board paid by tenant? $_____ Per ☐ Week ☐ Month Effective date _____

Owner Data

OWNER/MANAGER/CARETAKER NAME (Please print)	DAYTIME PHONE NUMBER			
STREET ADDRESS	CITY	COUNTY	STATE	ZIP CODE
NAME OF OWNER/MANAGER/CARETAKER COMPLETING FORM (Please print)	TITLE	PHONE NUMBER		

I hereby certify that the information above is complete, true and correct.

SIGNATURE OF OWNER/MANAGER/CARETAKER COMPLETING FORM	DATE

Attention. If you need free help interpreting this document, ask your worker or call the number below for your language.

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اطلب ذلك من مشرفك أو اتصل على الرقم 1-800-358-0377.

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមសួរអ្នកកាន់សំណុំរឿង របស់អ្នក ឬហៅទូរស័ព្ទមកលេខ 1-888-468-3787 ។

Pažnja. Ako vam treba besplatna pomoć za tumačenje ovog dokumenta, pitajte vašeg radnika ili nazovite 1-888-234-3785.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntawv no pub dawb, ces nug koj tus neeg lis dej num los sis hu rau 1-888-486-8377.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ຟຣີ, ຈົ່ງຖາມພະນັກງານກໍາກັບການຊ່ວຍເຫຼືອ ຂອງທ່ານ ຫຼື ໂທຣໄປທີ່ 1-888-487-8251.

Hubachiisa. Dokumentiin kun bilisa akka siif hiikamu gargaarsa hoo feete, hojjettoota kee gaafadhu ykn afaan ati dubbattuuf bilbilli 1-888-234-3798.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, обратитесь к своему социальному работнику или позвоните по телефону 1-888-562-5877.

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda qoraalkan, hawlwadeenkaaga weydiiso ama wac lambarka 1-888-547-8829.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, comuníquese con su trabajador o llame al 1-888-428-3438.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi nhân viên xã hội của quý vị hoặc gọi số 1-888-554-8759.

LB1-0001 (3-13)

ADA5 (12-12)

This information is available in accessible formats for individuals with disabilities by contacting your county worker. For other information on disability rights and protections to access human services programs, contact the agency's ADA coordinator.