GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HUMAN SERVICES

Consent and Release Form

AUTHORIZATION FOR RELEASE OF SNAP AND TANF INFORMATION FROM THE DISTRICT OF COLUMBIA DEPARTMENT OF HUMAN SERVICES TO THE DISTRICT OF COLUMBIA OFFICE OF THE STATE SUPERINTENDENT OF EDUCATION

SNAP or TANF Client Name: _____

Date of Birth: _____

Client Identification Number (CIN): _____

The District of Columbia ("District") Department of Human Services (DHS), Economic Security Administration (ESA), determines eligibility for the District's Temporary Assistance for Needy Families (TANF) and the Supplemental Nutritional Assistance Program (SNAP).

I _____, acknowledge and fully understand that, as a DHS client, my TANF and SNAP information is confidential and protected information pursuant to applicable District and federal confidentiality laws, including the District of Columbia Public Assistance Act of 1982, as amended (D.C. Official Code § 4-209.04), which states:

All information and records regarding an applicant or recipient provided to or created by the [ESA], its representatives, or its employees, in the course of the administration of [ESA] programs, shall be privileged and confidential." (D.C. Official Code § 4-209.04(c)).

By signing this form, I understand that I am allowing DHS to use or disclose confirmation of my receipt of TANF and/or SNAP benefits over a period of the prior 12 months ("Data") to the Office of the State Superintendent of Education for the purpose of District residency verification to determine eligibility under the District of Columbia Tuition Assistance Grant (DCTAG) program.
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Persons/organizations authorized to receive or use the information:

Name: Office of the State Superintendent of Education, DCTAG Program
Address: 1050 First Street NE, Washington, DC 20002
Phone Number: 202-727-2824

1. Purpose of the use/disclosure is for District residency verification over the prior 12 months to determine eligibility under the DCTAG program.

2. I understand that my SNAP and TANF benefits will not be affected if I do not sign this form.

3. I understand, with few exceptions, that I may see and copy the information described on this form if I ask for it, and that I may get a copy of this form after I sign it.

4. I may revoke this authorization at any time by notifying OSSE in writing at the address below, but, if I do, it will not have any effect on actions that OSSE or DHS took before they received the revocation. If not previously revoked, this authorization will expire upon completion of this request.

5. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan, health care provider or clearinghouse, the released information may no longer be protected by federal privacy regulations, and therefore the recipient of the Data may redisclose the Data.

6. I understand that both my SNAP and TANF information is confidential and protected by District and federal confidentiality laws. By signing this authorization, I am agreeing to waive this confidentiality and provide the Data to the third party listed above.

7. I acknowledge that I have read the provisions stated above, and/or an OSSE representative has verbally explained the provisions stated herein, and I voluntarily and knowingly consent to the release of the Data of my own free will.

8. This Authorization will expire upon use or one year from the date this form is signed, whichever comes first.

9. I acknowledge that I am an adult 18 years of age or older, and I fully understand and agree to the terms set forth above

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_____

Printed Name of Adult

_____

Address of Adult

_____ _____

Signature of Adult Date

_____

Printed Name of Witness

_____

Address of Witness

_____ _____

Signature of Witness Date

Please return this document by uploading it to your DCONEAPP portal under upload documents.