

HOUSING AUTHORITY CITY OF ELKHART

1396 BENHAM AVENUE Office# (574) 295-8392

Fax# (574) 293-6878 www.ehai.org ELKHART, INDIANA 46516 TTY# (574) 295-9682

Terry Walker, Executive Director

AUTHORIZATION FOR RELEASE OF INFORMATION USE FOR ALL PURPOSES CONSENT

I authorize and direct any Federal, State, or local agency, organization, business, or individual to release to Elkhart Housing Authority (EHA) any information or materials needed to complete and verify my application for participation, and/or to maintain my continued assistance under the Low Income Public Housing Program, and/or other housing assistance programs administered by the EHA. I understand and agree that this Authorization or the information obtained with its use may be given to and used by the Department of Housing and Urban Development (HUD) and USDA Rural Development in administering and enforcing program rules and policies.

In addition, I authorize and consent to the exchange of information between the EHA and supportive service agencies from whom I am receiving services concerning my family's circumstances, and/or other matters relating to my disability and/or medical condition.

INFORMATION COVERED

I understand that, depending on program policies and requirements, previous or current information regarding me or my household may be needed. Verification and inquires that may be requested include but are not limited to:

Identity and Marital Status Employment, Income, and Assets Medical or Child Care Allowances Credit and Criminal Activity

Residences and Rental Activity

I understand that this Authorization cannot be used to obtain any information about me that is not pertinent to my eligibility for and continued participation in a housing assistance program.

GROUPS OR INDIVIDUALS THAT MAY BE ASKED

The groups or individuals that may be asked to release the above information (depending on program requirements) include but are not limited to:

Previous Landlords (including Public Past and Present Employers Housing Agencies)

Credit Providers and Credit Bureaus

State Unemployment Agencies

Social Security Administration

Medical and Child Care Providers

Courts and Post Offices

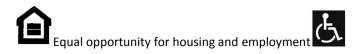
Schools and Colleges

Law Enforcement Agencies

Support and Alimony Providers

Veterans Administration Retirement Systems
Banks and other Financial Institutions Welfare Agencies

Utility Companies





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CONDITIONS

I agree that a photocopy of this Authorization may be used for the purposes stated above. The original of this Authorization is on file with the EHA and will stay in effect for a period of fifteen (15) months from the date signed. I understand I have a right to review my file and correct any information that I can prove is incorrect.

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Head of Household	[State(s) of Residency In Past 3 Years]	Date	
Spouse	[State(s) of Residency In Past 3 Years]	Date	_
Adult Member Signature	[State(s) of Residency In Past 3 Years]	 Date	_