

**Oneida Nation Comprehensive Housing Division
- Authorization for Release of Information -**



I, the undersigned, hereby authorize and direct any agencies, offices, groups, organizations, business or individuals to furnish information concerning myself and/or my household to the Comprehensive Housing Division (CHD), its duly authorized representative and/or its contracted agency for purpose of verifying my eligible to receive benefits from CHD.

Any individual or organization including any governmental agency may be asked to release information including, but not limited to: courts, law enforcement agencies, background screening agencies, employers, State Unemployment Agency, previous landlords, support and alimony providers, Social Security Administration, U.S. Department of Veterans Affairs, utility companies, medical professionals and facilities, child care providers, banks and other financial institutions, credit reporting agencies, social service and welfare agencies, public housing agencies, retirement systems, and schools/colleges.

I understand that, depending on program policies and requirements, verifications and inquiries that may be requested included, but are not limited to: identity, employment, income, marital status, residential history, household composition, medical expenses, assets, debts, credit history, criminal history, financial benefits, and school enrollment.

I agree that the Oneida Nation and CHD may conduct computer matching programs with other governmental agencies including federal, state, tribal, or local agencies. The government agencies include but are not limited to: U.S. Office of Personnel Management, U.S. Social Security Administration, U.S. Department of Defense, U.S. Postal Service, State Employment Security Agencies, and State Welfare and Food Stamp Agencies. The match will be used to verify information supplied by the applicant.

I understand that I have a right to review any information received in accordance with my release and have a right to correct any information that I can prove is correct.

I acknowledge that a photocopy or facsimile copy of this authorization may be deemed the equivalent of the original and may be used as a duplicate original.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization. If this authorization has not been revoked, it will terminate 12 months from the date signed.

I understand that if I, or any adult household member, fail to sign this authorization, or revoke this authorization prior to completion of necessary verifications and inquiries, it may constitute grounds for denial or termination of assistance or tenancy or both.

Applicant Signature	Print Name	Date	Social Security Number
Co-Applicant Signature	Print Name	Date	Social Security Number
Adult (18 & over) Member Signature	Print Name	Date	Social Security Number
Adult (18 & over) Member Signature	Print Name	Date	Social Security Number
Adult (18 & over) Member Signature	Print Name	Date	Social Security Number
Adult (18 & over) Member Signature	Print Name	Date	Social Security Number