DEPARTMENT OF HUMAN SERVICES

DHS-2952-ENG 8-22

CHILDREN AND FAMILY SERVICES – ECONOMIC ASSISTANCE AND EMPLOYMENT SUPPORTS

Authorization for Release of Information About Residence and Shelter Expenses

Date: 05-24-2023

Case number:
Worker name: Long Term Care Case Banking
Worker phone number: 218-824-1250
Agency email: cwcss@crowwing.us
Fax number: 218-824-1141
Worker agency: Crow Wing County Community Services IMU
Agency address: 204 Laurel St., P.O. Box 686
Brainerd, MN 56401

(Owner/manager/caretaker)
To: LAKES RECOVERY

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

404 4th Ave Ne
Brainerd MN 56401-2727

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
SIGNATURE OF SPOUSE/GUARDIAN/AUTHORIZED REPRESENTATIVE	DATE	Provide copy to client

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	COUNTY
			Crow Wing

STREET ADDRESS	APARTMENT NUMBER	CITY	STATE	ZIP CODE

Rental Information

DATE MOVED IN	NUMBER OF ADULTS IN UNIT	NUMBER OF CHILDREN IN UNIT	TOTAL RENT FOR UNIT

DAMAGE DEPOSIT	PAID
	◯ Yes ◯ No

Does the rent amount include payment for meals? ◯ Yes ◯ No If yes, how much of the rent is paid for meals _____

AMOUNT OF RENT **PAID BY TENANT**	PER	EFFECTIVE DATE
	◯ Week ◯ Month ◯ Other _____	

Is any portion of the rent **paid by rental subsidy?** ◯ No ◯ Yes If yes, check which type of subsidy:

☐ Public Housing ☐ HUD project properties ☐ Section 8

☐ **Other** _____ List the amount of the subsidy _____

Check which utilities the tenant is responsible to pay separate from the rent amount

☐ Gas ☐ Electricity ☐ Garbage Removal ☐ Water and sewer ☐ Air conditioning ☐ Heat

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

☐ None ☐ Other _____

Is any portion of the rent and/or utilility costs **paid by Housing Support?** ◯ Yes ◯ No

Caretaking or Other Tenant Responsibilities

Is the rent reduced by caretaking or other such responsibilities? ◯ No ◯ Yes If yes, amount: _____

Can the tenant do the following:

1. Receive pay for caretaking or other tenant services provided? ◯ No ◯ Yes If yes, amount: _____
2. Choose to receive pay rather than a reduction in rent? ◯ No ◯ Yes If yes, amount: _____

Owner Data

PROPERTY OWNER NAME (Please print)	DAYTIME PHONE NUMBER

STREET ADDRESS	CITY	COUNTY	STATE	ZIP CODE

NAME OF OWNER/MANAGER/CARETAKER COMPLETING FORM (Please print)	TITLE

EMAIL ADDRESS	PHONE NUMBER

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

SIGNATURE OF OWNER/MANAGER/CARETAKER COMPLETING FORM	DATE