CAPITAL AREA HOUSING PARTNERSHIP
AUTHORIZATION FOR RELEASE OF INFORMATION AND PRIVACY ACT NOTICE

Issued under P.A. 346 of 1966, as amended, and Section 8 of the U.S. Housing Act of 1937.
Failure to comply will result in denial of benefits.

The undersigned authorize Capital Area Housing Partnership and/or its contracted agent to contact any agencies, office, groups, organizations, or employers to obtain, and agencies to release, information that is pertinent to eligibility, level of benefits, or continued participation the CDBG, HOME and/or MSHDA Housing Resource Fund (HRF) Programs, including authorization to obtain a consumers credit report.

This includes the Social Security Administration (SSA), Immigration and Naturalization Service (INS), and the State of Michigan Department of Human Services (DHS) Medicaid Program and Food Assistance Program. CAHP may use this Authorization and the information obtained with it, to administer and enforce program rules and policies.

The undersigned certify that the information given to CAHP on household members, income, net family assets, allowance, and deductions is accurate.

PRIVACY ACT NOTICE STATEMENT: THE DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT (HUD) IS REQUIRING THE COLLECTION OF THIS INFORMATION TO DETERMINE AN APPLICANT'S ELIGIBILITY AND THE AMOUNT OF ASSISTANCE NECESSARY. THIS INFORMATION WILL BE USED TO ESTABLISH LEVEL OF BENEFIT, TO PROTECT THE GOVERNMENT'S FINANCIAL INTEREST; AND TO VERIFY THE ACCURACY OF THE INFORMATION FURNISHED. IT MAY BE RELEASED TO APPROPRIATE FEDERAL, STATE, AND LOCAL AGENCIES WHEN RELEVANT, TO CIVIL, CRIMINAL, OR REGULATORY INVESTIGATORS, AND TO PROSECUTORS. FAILURE TO PROVIDE ANY INFORMATION MAY RESULT IN A DELAY OR REJECTION OF YOUR ELIGIBILITY APPROVAL. HUD IS AUTHORIZED TO ASK FOR THIS INFORMATION BY THE NATIONAL AFFORDABLE HOUSING ACT OF 1990.

I ACKNOWLEDGE THAT (1) A PHOTOCOPY OF THIS FORM IS AS VALID AS THE ORIGINAL, (2) I HAVE THE RIGHT TO REVIEW THE FILE AND INFORMATION RECEIVED USING THIS FORM (WITH A PERSON OF MY CHOOSING TO ACCOMPANY ME), (3) I HAVE THE RIGHT TO COPY INFORMATION FROM THIS FILE AND TO REQUEST CORRECTION OF INFORMATION THAT I BELIEVE INACCURATE.

ALL ADULT HOUSEHOLD MEMBERS WILL SIGN THIS FORM AND COOPERATE IN THIS PROCESS.

I agree that copies of this Authorization may be used for the purposes stated above. This consent will expire 15 months from the date signed.

Signature of Head of Household	Social Security Number	Date
Signature of Spouse	Social Security Number	Date
Other Adult Signature (If Applicable)	Social Security Number	Date
Other Adult Signature (If Applicable)	Social Security Number	Date
Other Adult Signature (If Applicable)	Social Security Number	Date

Return completed form to:
CAHP
600 W Maple St, Ste D
Lansing, MI 48906

I understand that willfully submitting any false information in this statement may subject me (us) to criminal or civil action, and will also cause my (our) disqualification for benefits under the CAHP programs.