Tenant ID:

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL DEPARTMENT OF PUBLIC SOCIAL SERVICES INFORMATION

THE LOS ANGELES COUNTY DEVELOPMENT AUTHORITY (LACDA) REQUIRES YOUR SIGNATURE ON THIS CONSENT FORM TO VERIFY INCOME FROM PROGRAMS ADMINISTERED BY THE LOS ANGELES COUNTY DEPARTMENT OF PUBLIC SOCIAL SERVICES (DPSS). DPSS, NOR ANY PROGRAM IT ADMINISTERS, REQUIRES YOUR SIGNATURE ON THIS FORM.

As a requirement of LACDA's housing assistance programs, I consent to allow the LACDA to request and obtain income information from DPSS for the purpose of verifying my eligibility and level of benefits under the U.S. Department of Housing and Urban Development's assisted housing programs. I understand that by signing below, DPSS will share the information they have about me, including whether I receive public assistance, the amount of any assistance, first and last name of all persons receiving aid, authorized amount for the payee only, case approval date, termination date of aid and the sanctions/income reduction information.

Instructions:
The box below must be completed for any household member(s) that receive Public Assistance Benefits administered by DPSS. You must provide the member first name, last name, and benefit type.

	Household Member Name	Income Type
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

I understand that I have a right to the privacy of my personal information. I understand that provisions of law protect my information and identity as an applicant or recipient of public assistance.

I understand that by signing this below, I am voluntarily authorizing DPSS, its agents and employees to share the information they have about me. I acknowledge that before signing this Authorization Form, I have carefully read and fully understand its terms. I understand that my refusal to sign this Authorization Form will not impact the services I currently receive or am eligible to receive through DPSS; however, refusal to sign may lead to termination of my housing assistance provided by the LACDA. I understand that I have the right to revoke this authorization at any time by saying so in writing.

This consent form expires 15 months from the date it is signed.

Household Member Name (print name)	Signature	Date
Household Member Name (print name)	Signature	Date
Household Member Name (print name)	Signature	Date
Household Member Name (print name)	Signature	Date