The Arc Oregon

AUTHORIZATION FOR DISCLOSURE OF FINANCIAL INFORMATION

PURPOSE:

For you to authorize disclosure of financial information related to your pooled trust subaccount for the purposes of benefit recertification. This authorization will allow the Oregon Special Needs Trust staff to provide trust information as requested to any federal, state or local agency for the sole purpose of proving eligibility for public benefits. Disclosure may include copies of trust documents, account balance statements, and/or additional documentation regarding trust deposits and expenditures.

BENEFICIARY INFORMATION:

Beneficiary Name: _____

Account Number: _____

Address: _____

City, State, Zip: _____

Last 4#'s of Social Security # _____ Date of Birth: _____

PROGRAMS:

To which benefit programs are you authorizing us to disclose your trust account information?

☐ Medicaid/OHP ☐ Social Security ☐ Housing ☐ SNAP/Food Stamps

Other: _____

EXPIRATION:

I understand that I may cancel this consent upon written notice at any time, except to the extent that action has been taken based upon this consent before cancellation.

☐ By checking this box, this authorization will remain in effect as long as the trust account is open, and the trust beneficiary receives public benefits from the program(s) indicated above.

☐ By checking this box, I authorize this release to remain in effect until: _____

_____ _____

Signature of Authorized Person Date

_____

If the above Signature is NOT that of the Beneficiary, print name and describe authority to represent.

Mail ORIGINAL completed form to:

THE ARC OREGON, 2405 FRONT STREET NE, SUITE 120, SALEM OR 97301