| YES | NO | | |
|---|---|---|---|
| ☐ | ☐ | 16. | **I further understand** that I may receive information/services on Domestic Violence upon request. |

| YES | NO | | |
|---|---|---|---|
| ☐ | ☐ | 17. | **I understand** that appointments/meetings with my Worker may include scheduled/unscheduled home visits, but **I also understand** that I am not required to allow the DHHR Worker to enter my home. |

| YES | NO | | |
|---|---|---|---|
| ☐ | ☐ | 18. | **I understand** that I may be qualified to apply for low-priced telephone service called Tel-Assistance/Lifeline that the telephone company in my area offers. I give permission to DHHR to release information to the telephone company concerning my eligibility for this service. If my eligibility for DHHR programs is stopped, I understand DHHR will notify the telephone company. |

| YES | NO | | |
|---|---|---|---|
| ☐ | ☐ | 19. | **I understand** that I will be required to cooperate with the Quality Assurance Reviewer in any review of my benefits as a matter of eligibility. This may require a home visit by the Reviewer and include additional verification of my situation. |

| YES | NO | | |
|---|---|---|---|
| ☐ | ☐ | 20. | **I give my permission** for any financial institution, government agency or department; landlords, both private and public housing authorities; physician, including psychiatrists, psychologist or other counselor; drug testing facility; hospital, including psychiatric hospitals; business concern/employers; HIV/AIDS testing services; other person with related information to give any information to an employee of the Department which would have to do with my receiving assistance and which is required by federal regulations and/or Department policy. This release authorizes schools to provide information including, but not limited to, enrollment, attendance, address, custodian, and all information related to the receipt of public assistance for my child(ren) under my care and custody. |

| YES | NO | | |
|---|---|---|---|
| ☐ | ☐ | 21. | **I give my permission** to the Department of Health and Human Resources to refer my family to any helping agency for needed service after my benefits end. |

| YES | NO | | |
|---|---|---|---|
| ☐ | ☐ | 22. | **I give my permission** specifically to the West Virginia State Tax and Revenue Department and the Internal Revenue Service to release to the West Virginia Department of Health and Human Resources any and all information from my personal and/or business income tax returns for any and all tax years that would have to do with my receiving benefits and which is required by federal regulations and/or department policy. This includes filing status, dependents, address, income, deductions, and any other pertinent information requested by DHHR. |

**I certify** that all statements on this form have been read by me or read to me and I understand the questions. I certify that all the information I have given is true and correct and I accept the aforementioned responsibilities.

| | |
|---|---|
| Applicant's Signature | Date Signed |
| Co-Applicant's Signature | Date Signed |
| Worker's Signature | Date Signed |
| Representative Completing Application Form | Date Signed |

**DFA-MA-1 (New 12/11, Revised 9/17/12)**