NUTRITION ASSISTANCE PROGRAM

Department of Community & Cultural Affairs
Commonwealth of the Northern Mariana Islands
Saipan, MP 96950

AUTHORIZATION FOR RELEASE OF INFORMATION

I, ________________________________ *Re. Case No.:* __________
(Name)

residing at ____
(Place of Residence and Dist. No.)

____ *, hereby authorize*
(Island and Zip Code)

The NAP Administator or his designees to verify my income, checking accounts, savings accounts, shelter expenses, medical expenses, insurance, SS benefit, SSI benefit, retirement pension, veterans benefit, medical history, any and all tax Information on file with the CNMI Division of Revenue and Taxation and CNMI Social Security Administration and any other facts relevant to my Household's eligibility for participation in the Nutrition Assistance Program.

I also authorized any person, partnership, corporation, association or government agency possessing information on such matters to release such information to the Administrator or his duty authorized designees.

I CERTIFY that I have received and read the declaration concerning my rights under Privacy Act of 1974	________________ Print Name & Sign	________ Date

Benefits may be authorized under this Program pursuant to existing regulation, (re. 7CFR 270-273).

PART A- (NAP Case File) Revised 8/05

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PART B- (To be given to Household) Revised 8/05