Community Action Team
Serving Columbia, Clatsop, and Tillamook Counties

phone (503) 397-3511
fax (503) 397-3290
www.cat-team.org

TO:

FROM: _____

Return via Fax: _____

Or email: _____

Subject: Verification of information supplied by an applicant for Head Start

Adult's Name: _____ Date of Birth: _____

Child's Name: _____ Date of Birth: _____

Address: _____

_____

This person has applied for Head Start and indicated they receive public assistance. We ask your cooperation in providing the following information and returning it to the fax number or email above. The applicant has consented to this release of information as shown below.

The applicant currently receives.

TANF	Yes ☐	No ☐
SNAP	Yes ☐	No ☐
SSI	Yes ☐	No ☐

Name and Signature of Person supplying information:

Tillamook DHS
Fax: (503) 842-2183
Attention: SSP Manager

Astoria DHS
Fax: (503) 325-6506

St. Helens DHS
FAX: (503) 397-0942

Signature Signature Signature

Release: I hereby authorize the release of the requested information. Information obtained under this consent is limited to information that is no older than 12 months. There are circumstances which would require the owner to verify information that is more than 12 months old, which would be authorized by me on a separate consent attached to a copy of this consent.

Parent/Guardian Signature Date

Family Resource Center
125 North 17th Street
Saint Helens, OR 97051

Fiscal Office
124 North 18th Street
Saint Helens, OR 97051

Child & Family Programs
108 West B Street
Rainier, OR 97048