INDIANA WORKFORCE DEVELOPMENT AND ITS WorkOne CENTERS

RELEASE OF INFORMATION

***NAME OF APPLICAN (PRINT) _____**

***SOCIAL SECURITY: _____**

***CURRENT DATE: _____**

I authorize the Indiana Department of Workforce Development to release all wage and unemployment benefit information to the agency listed below.

_____

***SIGNATURE OF APPLICANT**

☐ **Check this box if Power of Attorney is attached**

By signing below you agree that you understand that data we release to you is protected under state law (IC 22-4-19-6) and federal regulations (20 CFR § 603.5) as confidential information. You also confirm that you have verified the applicant's identity by viewing some type of photo identification.
***NOTE: RELEASE MUST BE SUBMITTED WITHIN 90 DAYS OF APPLICANT SIGNING RELEASE FORM.**

***Signature of Requestor: _____**

Requesting Agency: South Central Community Action Program

Fax Number: 812-334-8366

***REQUIRED FIELDS: For questions email EmployVerification@dwd.IN.gov**