



INDIANA
WORKFORCE
DEVELOPMENT
AND ITS **WorkOne** CENTERS

RELEASE OF INFORMATION

*NAME OF APPLICANT (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