The Lighthouse and Move UP
VTA TANF Fare-Free Grant Funded 'Free Rides to Work' Program

SELF-DISCLOSURE FORM FOR PROGRAM PARTICIPANTS:

I, _____(print name), agree that I meet one of the following criteria for eligibility for TANF (Temporary Assistance for Needy Families) and thus the free-rides-to-work program. I understand The Lighthouse may access DSS and LRHA records regarding my income, dependents, and household expenses which determines my eligibility for TANF. I do not have to currently be receiving TANF, but I understand I must meet the eligibility criteria, as outlined below.

I understand that if I am found to not be eligible, I will be responsible for repayment of rides at the rate of $2.80 per mile to $80 per ride. This will be collected by MoveUP per their terms of use.

By signing below, I certify that I meet the following criteria AND I authorize the Lighthouse to obtain information from the Department of Social Services and/or Lynchburg Redevelopment Housing Authority to verify my eligibility.

☐ I am an income-qualified individual with a dependent child and whose income is at or below 200 percent of the poverty level (see table to the right).

- The definition of dependent child per TANF guidance is: child is under the age of 18 years or if 18, but not yet 19, is enrolled and attending a secondary school or vocational/technical school of secondary equivalency and is meeting the enrollment and attendance requirements as determined by the local school

☐ I am a non-custodial parent who is providing financial support for my child(ren). I may qualify for the Transit Zero-Fare grant program if my income is at or below 200 percent of the poverty level (see table to the right) and provides verification of child-support payments.

200% Poverty Level 2023
for the 48 Contiguous States

# of Persons in Household	Annual Household Income
1	$14,580
2	$19,720
3	$24,860
4	$30,000
5	$35,140
6	$40,280
7	$45,420
8	$50,560
Add $5,140 for each person in household over 8 persons	

Signature: _____ Date: _____

Witness (*if required*): _____ Date: _____

COMMONWEALTH OF VIRGINIA
UNIFORM AUTHORIZATION TO USE AND EXCHANGE INFORMATION

I understand that different agencies provide different services and benefits. Each agency must have specific information to provide services and benefits. By signing this form, I allow agencies to use and exchange certain information about me, including information in an electronic database, so it will be easier for them to work together efficiently to provide or coordinate these services or benefits.

I, _____, am signing this form for
(FULL PRINTED NAME OF AUTHORIZING PERSON OR PERSONS)
_____*(FULL PRINTED NAME OF INDIVIDUAL)*
_____
(INDIVIDUAL'S ADDRESS) *(INDIVIDUAL'S BIRTH DATE)* *(INDIVIDUAL'S SSN – OPTIONAL)*

My relationship to the individual is: ☐ Self ☐ Parent ☐ Power of Attorney ☐ Other Legally Authorized Representative

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I want the following confidential information about the individual to be exchanged:

Yes	*No*		*Yes*	*No*		*Yes*	*No*	
☒	☐	Assessment Information	☐	☒	Medical Diagnosis	☐	☒	Educational Records
☒	☐	Financial Information	☐	☒	Mental Health Diagnosis	☐	☒	Psychiatric Records
☒	☐	Benefits/Services Needed, and/or Received	☐	☒	Medical Records	☐	☒	Criminal Justice Records Planned,
☐	☒	Substance Abuse Records	☐	☒	Psychological Records	☐	☒	Employment Records
						☐	☒	All of the Above

Other Information (write in): _____

I want: City of Lynchburg Dept. of Social Services; 99 9th Street, Lynchburg, VA 24504

To exchange information related my eligibility for the **Lighthouse and Move UP, Free Rides to Work Program**

I want this information to be exchanged ONLY for the following purpose(s):
☐ Service Coordination and Treatment Planning ☒ Eligibility Determination
☐ Other: _____

I want this information to be shared by the following means: *(check all that apply)*
☒ Written Information ☒ In Meetings or By Phone ☒ Computerized Data ☒ Fax

I want to share additional information received after this authorization is signed: ☐ Yes ☐ No

This authorization is effective: _____
(DATE)

This authorization is good until: ☒ My service case is closed. ☐ Other: _____
For No Wrong Door this authorization is valid for one year from date of signature, unless the individual or his authorized representative specify an expiration date, event or condition that will occur prior to one year from the date of signature.

I can withdraw this authorization at any time by telling the referring agency. The listed agencies must stop sharing information after they know my authorization has been withdrawn. I have the right to know what information about me has been shared, and why, when, and with whom it was shared. If I ask, each agency will show me this information. I want all agencies to accept a copy of this form as valid authorization to share information. **If I do not sign this form, information will not be shared and I will have to contact each agency individually to give information about me that is needed.** However, I understand that treatment and services cannot be conditioned upon whether I sign this authorization. There is a potential for information disclosed pursuant to this authorization to be re-disclosed by the recipient and not be subject to the HIPAA Privacy Rule.

Signature(s): _____ Date: _____
(AUTHORIZING PERSON OR PERSONS)

Person Explaining Form: _____
(Name) *(Address)* *(Phone Number)*

Witness *(If Required)*: _____
(Signature) *(Address)* *(Phone Number)*