



This Release of Information Form is to be completed separately for all members of the household. Where the form is completed for a child, it should be signed by an adult with parental responsibility for that child. It may also be signed by a representative where the adult is unable to sign for themselves.

The intention of this document is to facilitate the delivery of financial assistance by providing authorization for the Department of Financial Assistance to communicate with external organizations.

The Department has authorization to gather information as is reasonably required for the delivery of financial assistance in regards to household members as per the Financial Assistance Act, 2022 and associated Regulations.

Your personal information is protected by law, including the Data Protection Act (2021 Revision). The Department of Financial Assistance will only collect the information which is necessary to render services to you. The Department of Financial Assistance will only provide third parties with information about you which relates to your application or services from the Department. We may also share information with other entities to ensure that you receive the right level of support.

You can request to access any information that we hold about you through the Freedom of Information Act or Data Protection Act, as relevant. If you have a concern and wish to make a complaint, you may contact us at [DFACCompliance@gov.ky](mailto:DFACCompliance@gov.ky). If you wish to see more details about how we process any data shared with us, please view the Privacy Notice on our website at [dfa.gov.ky](http://dfa.gov.ky).

|   |  |  |  |
|---|--|--|--|
| <b>Application ID</b>                       | <input type="text"/>                                     | <b>FAS ID</b>                                | <input type="text"/>                     |
| <b>Name of Household Member</b>             | <b>Date of Birth</b>                                     |  | <input type="text" value="dd/mm/yyyy"/>  |
| <input type="text" value="First Name"/>     | <input type="text" value="Middle Name"/>                 | <input type="text" value="Last Name"/>       |  |
| <b>Name of Household Member (AKA)</b>       |  |  |  |
| <input type="text" value="First Name"/>     | <input type="text" value="Middle Name"/>                 | <input type="text" value="Last Name"/>       |  |
| <b>Name of Household Member (AKA)</b>       |  |  |  |
| <input type="text" value="First Name"/>     | <input type="text" value="Middle Name"/>                 | <input type="text" value="Last Name"/>       |  |
| <b>Physical Address of Household Member</b> |  |  |  |
| <input type="text" value="House#"/>         | <input type="text" value="Street Name"/>                 |  |  |
| <input type="text" value="Apt#"/>           | <input type="text" value="Bldg Name"/>                   | <input type="text" value="District/Island"/> |  |
| <b>Mailing Address</b>                      | <input type="text" value="P.O. Box"/>                    | <input type="text" value="Postal Code"/>     | <input type="text" value="Post Office"/> |
| <b>General Delivery</b>                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |

If you are a business owner please include your business name and details below. If you are an owner of multiple businesses, please list all.

|                         |                      |
|-------------------------|----------------------|
| <b>Business Name</b>    | <input type="text"/> |
| <b>Business Address</b> | <input type="text"/> |
| <b>Business Name</b>    | <input type="text"/> |
| <b>Business Address</b> | <input type="text"/> |

I, \_\_\_\_\_ (household member) give authorization for the exchange of information between the Department of Financial Assistance and the following agencies and/or persons in order to access the necessary services for myself and/or my household.

I understand that contact will only be made in the instance where information is needed from that entity/financial institution/person or where the Department of Financial Assistance needs to share pertinent information with another agency or person in order for my household and/or I to obtain services.

I understand that refusal to give such authorization will result in my household and/or me not being able to access services via the Department of Financial Assistance.

**The following organizations/individuals are a required organization/individual to provide authorization for information sharing:**

- All Public Authorities; Ministries, Portfolios, Offices, Departments, Statutory Authorities, Statutory Bodies and Government Companies.
- All Cayman Islands Local Banks and Money Transfer Agencies
- All Health Insurance Companies, Pension Companies and Educational Institutions
- All Local Churches, Service Clubs and other Not-For-Profit Organizations
- Employer
- Utility Companies, Landlords, Hotels and Other Accommodations
- Vendors of Services Requested
- Consulates
- Attorneys / Barristers / Lawyers

**Please specify any other entities or individuals that you would like to provide consent for information sharing:**

**Name of Individual or Organization**

**Contact Name**

**Telephone**

**Email Address**

**Name of Individual or Organization**

**Contact Name**

**Telephone**

**Email Address**

Where information which could affect your financial assistance has been brought to the attention of the Department which cannot be verified with you, this form authorizes us to make reasonable enquiries with organizations beyond those specified here.

Visit us at [dfa.gov.ky](https://dfa.gov.ky) to view the Department's [Privacy Notice](#) and learn more about the circumstances in which the Department contacts the above organizations.

I, \_\_\_\_\_ (household member) give authorization to the Department of Financial Assistance to enable them to share information with the entities/financial institutions/persons identified above and for those agencies/persons identified above to provide the Department of Financial Assistance with information relevant to myself and/or my household's case history and circumstances. Information can be requested and shared verbally, in writing or through checking of system records.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**If this form is being completed by the authorized representative for the applicant/recipient, the below needs to be completed.**

I, \_\_\_\_\_ (representative), confirm that the information provided above is accurate and truthful to the best of my knowledge.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Thank you for completing this form. This form can be submitted online by visiting [dfa.gov.ky](https://dfa.gov.ky) or via email to [dfainfo@gov.ky](mailto:dfainfo@gov.ky).