

Faith Assistance Contract

I, _____, am receiving assistance in the amount of _____ from the Wilson County Department of Social Services Faith Connections Program; therefore I will not contact the following partnering agencies for assistance:

Calvary Presbyterian Church
Christ Deliverance Tabernacle Ministries
Contending For the Faith Church
Ministries
Daniel's Chapel Free Will Baptist Church
Farmington Heights Church of God
Feel Free Church Ministries
First Baptist Church
First Christian Church
First Presbyterian Church, PCUSA
First United Methodist Church
Forest Hills Baptist Church
Light & Life Pentecostal Church of
Deliverance
Little Rock OFW Baptist Church
Lively Stone Church of Deliverance/
Outreach Center
Peace Church
St. John A.M.E. Zion Church
St. Timothy's Episcopal Church
West Nash Methodist Church

If I do choose to contact the above agencies for assistance, I understand that I may be jeopardizing my eligibility to receive any further assistance from the Wilson County Department of Social Services Faith Connections Program.

Signed _____

Date _____

WILSON COUNTY DEPARTMENT OF SOCIAL SERVICES
Faith Connections
Release of Information
Date _____

I hereby authorize the Wilson County Department of Social Services/Faith Connections to release/obtain information from the record of _____ to/from the following agency(ies); Wilson Technical Community College; NEED, Inc; Opportunities Industrial Commission; Vocational Rehabilitation, Employment Security Commission, Hope Station, Salvation Army, Wilson County Faith Partners, other WCDSS departments, other: _____.

I further authorize those agencies to release information from the record of _____ to Wilson County Department of Social Services and the Faith Connections Program. This information shall include: educational status, testing results, level of performance and/or progress, attendance, and general employment potential, other: _____. This information shall include criminal history to be released to assisting partners with the Wilson County Department of Social Services/Faith Connections. I understand this information will be used for determining possible care plans for aiding in the requested assistance.

I understand the contents to be released, the need for the information, and that there are statutes and regulations protecting the confidentiality of authorized information. I hereby acknowledge that this consent is truly voluntary and is valid for one year from date of signature. I understand that I may revoke this consent at any time except to the extent that information has already been released before I revoke it.

_____ Or _____
Signature of Participant Authorized Representative

Participant's Social Security Number

Witness Date
(Necessary only if client signs with an "X")