



Welfare Benefits Release

I / We hereby authorize the Welfare Office listed below to release information concerning my / our monthly benefits to the Student Financial Aid Office of the University of Medicine and Dentistry of New Jersey.

Location: _____ County Welfare Office

Street Address

City

State

Zip Code

Caseworker's Name (Please Print)

Case Number

Student's Name (Please Print)

Parent's Name (Please Print)

Student's Signature

Date

Parent's Signature

Date

University Identification Number (UIN) School

Parent's SSN

STUDENT: COMPLETE ABOVE & RETURN TO THE STUDENT FINANCIAL AID OFFICE

TO: Welfare Office

PLEASE RETURN TO:

FROM: UMDNJ Student Financial Aid Office

RE: Monthly Benefits

Please certify the amount of monthly benefits paid to **all** members of the family receiving assistance under the case number listed above and return this form to our office. Thank you.

The family of _____ has been receiving \$ _____ per month for _____ months during the **previous** calendar year. They [] **are** [] **are not** currently receiving benefits.

Comments (if any): _____

Signature of Caseworker

Title

Date