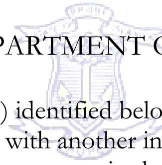

RHODE ISLAND DEPARTMENT OF HUMAN SERVICES

Please furnish the following information regarding the person(s) identified below. The information is needed only on those accounts in which the individual is an owner of the account either singly or jointly with another individual(s). We are not interested in those accounts in which the person identified below is a beneficiary on the account. Please return in the enclosed envelope. Thank you.

ADDRESS OF BANK'S MAIN OFFICE

TO: ______________________________
____
____

NAME & ADDRESS OF RI DHS REPRESENTATIVE

FROM:

____

Last Name **First Name** **MI**

____

Address **City** **State** **Zip**

______________________ ______________________ ______________________

Birth date **Birthplace** **Social Security Number**

- -

Children's Names	**Date of Birth**	**Social Security Number**
1.______________	______________	______________
2.______________	______________	______________
3.______________	______________	______________
4.______________	______________	______________
5.______________	______________	______________
6.______________	______________	______________

BANK REPORT

(To be filled in and signed by Bank Representative)

___ **No Record of Account**

___ **Open Account:**

Name(s) on Account: ____

Checking Account (s) **Account #**______________________

Current Balance $______________
Date Opened__________________

Current Balance $______________
Date Opened__________________

Savings Account (s) **Account #**____________________

Current Balance $______________
Date Opened__________________

Current Balance $______________
Date Opened__________________

___ **Other Asset Account (s):** **Account #**______________________________

Type of Account ______________ Current Balance $______________ Date Opened__________________
Type of Account ______________ Current Balance $______________ Date Opened__________________

___ **Closed Account Within Past 60 Months:**
Type of Account______________ Date Opened ______________ Date Closed___________
Type of Account______________ Date Opened ______________ Date Closed___________

___ **Safe Deposit Box:** _____ Yes _____ No Record

Signed: ______________________________ ______________

Bank Representative **Date**

I, ______________________________ of ______________________________ hereby authorize the release of all bank information that is required to determine my eligibility for any or all of the following programs: the FIP cash program, the GPA program, the Medical Assistance program, the Food Stamp Program, the Child Care Assistance Program.
I understand that this bank information is confidential and is to be used only for determining my eligibility for benefits.

______________________________ ______________ ______________________

(Signature of Client) **Date** **(Social Security Number)**