

CONFIDENTIALITY AGREEMENT

I, _____, (title) _____ at _____ Correction Facility have been designated to take Temporary Assistance and Medical Assistance applications on behalf of the _____ County Department of Social Services. I understand that all communications, information and documents received by me in the course of conducting a Temporary Assistance and/or Medical Assistance eligibility review are confidential and may not be disclosed by me to anyone except the applicant for or recipient of temporary assistance or medical assistance and persons authorized to have such information for the purpose of making eligibility determinations for temporary assistance or medical assistance.

I understand that any violation of the provisions of this agreement is unlawful and may subject me to loss of my status as a designated interviewer as well as any other penalties prescribed by law.

Signature

Print Full Name

Date

Witness