



Department of Public Health and Social Services
Division of Public Welfare ♦ Bureau of Economic Security
Bureau of Management Support
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Telephone 735-7245 (BES) / 735-7344 (BMS)
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CONSENT FOR RELEASE OF CHILD CARE CERTIFICATE

Client Name: (Please Print)	Social Security Number:/Case Number:								
<table style="width: 100%;"><tr><td style="width: 60%;">Authorized Person(s)/Center Name: (Maximum of 3) (Example) Jane Doe, Director / Block Grant Day Care Center</td><td style="width: 40%;">Relationship to Client: (Example) Day Care Provider</td></tr></table> <table style="width: 100%;"><tr><td style="width: 60%;">1. _____</td><td style="width: 40%;">_____</td></tr><tr><td>2. _____</td><td>_____</td></tr><tr><td>3. _____</td><td>_____</td></tr></table> <p style="text-align: center;">COPY OF PICTURE ID FOR AUTHORIZED PERSON(S) IS REQUIRED</p>		Authorized Person(s)/Center Name: (Maximum of 3) (Example) Jane Doe, Director / Block Grant Day Care Center	Relationship to Client: (Example) Day Care Provider	1. _____	_____	2. _____	_____	3. _____	_____
Authorized Person(s)/Center Name: (Maximum of 3) (Example) Jane Doe, Director / Block Grant Day Care Center	Relationship to Client: (Example) Day Care Provider								
1. _____	_____								
2. _____	_____								
3. _____	_____								
<p>I hereby authorize the Department of Public Health and Social Services to release the child care certificate(s) to the individual(s) and/or provider(s) identified above for: (SELECT ONE ONLY)</p> <p>[<input type="checkbox"/>] Only for the service month of _____ .</p> <p>OR</p> <p>[<input type="checkbox"/>] All certificates within my certification period: _____ to _____ Month/Year Month/Year</p> <p>I understand:</p> <ul style="list-style-type: none">a) that it is my responsibility to provide the child care certificate to my provider(s). However, if I am unable to pick up the certificate, I am authorizing the individual(s) and/or Provider to pick up my certificate(s) on my behalf.b) that I can revoke this authorization at any time but must do so in writing and that I am responsible for informing the individuals identified in this consent form.c) this consent will expire at the end of my certification period. It will also become invalid when my application is denied or when my case is terminated. <p>Client Signature: _____ Date: _____</p> <p>Authorized BES or BMS Staff: _____ Date: _____</p>									