



# SIGNATURE AUTHORIZATION FORM

Please Print Clearly

If the person you would like to be authorized to sign all Housing Authority related documentation on your behalf is the representative of an advocacy agency, the name and address of that Agency must be noted in the applicable place.

**PURPOSE:** This form allows you to authorize another person to sign all Housing Authority-related documents on your behalf. You may only submit this form if the Housing Authority verifies that you have a disability.

Head of Household Name: \_\_\_\_\_

I authorize the following person (“Authorized Person”):

Person’s Name: \_\_\_\_\_ Agency (if applicable): \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

State Reason for Request:

\_\_\_\_\_  
\_\_\_\_\_

I authorize the above-referenced person to: (Head of household must initial below)

\_\_\_\_\_ **Sign documents on my behalf.** This is permitted only if the tenant’s disability prevents them from signing his/her own name. The Authorized Person must sign their own signature, then print “for [HEAD OF HOUSEHOLD NAME]” underneath.

Please provide the name and address of a health care provider or social worker who can verify the disability in the space below and the Housing Authority will contact this person directly. **Please note that this form will not be approved without disability verification. If you include contact information that is incomplete or incorrect, this form will be returned to you to complete and/or correct which will delay the processing of your request.** By signing this form, I authorize my health care provider or social worker to release information to the Housing Authority regarding my disability.

Name of health care provider / social worker: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

It is my responsibility to communicate with the Authorized Person about actions he or she has taken on my behalf. I understand that this agreement does not release me from my responsibility to comply with program requirements. I understand that I am responsible for complying with any and all agreements entered into on my behalf and signed by the Authorized Person. Nothing in this agreement prevents me from acting on my own behalf. I understand that I may continue to sign documents myself. This agreement will not expire unless I notify the Housing Authority in writing that I would like to cancel it. This agreement is not effective unless the Housing Authority approves it by signing below. You will be informed of the Housing Authority’s granting, denial, or status of this request within thirty (30) days of the receipt of this request.

\_\_\_\_\_  
Head of Household Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Authorized Person Signature

\_\_\_\_\_  
Authorized Person Name (Print or Type)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Housing Authority Approval – Administration Department

\_\_\_\_\_  
Date

If you have any questions regarding this, please contact the Housing Authority at (831) 454-5955 Monday through Thursday, between 8:00 AM – 4:30 PM.