



# Southwest Michigan Community Action Agency

SERVING BERRIEN, CASS, AND VAN BUREN COUNTIES

*Helping People. Changing Lives.*



185 E. Main St., Suite 303  
Benton Harbor, MI 49022

Tel: (269) 925-9077  
Fax: (269) 934-8242  
contact@smcaa.com  
www.smcaa.com

## Release of Information Form

<b>Applicant Name:</b>		<b>Date:</b>	
<b>Physical Address:</b>			
<b>City/State/Zip:</b>			

***All Household Members over the age of 18 years MUST sign the Release of Information Form.***

I grant permission to Southwest Michigan Community Action Agency (SMCAA):

- Provide my social security number and other personal information to state and federal agencies for the purpose of determining and confirming my eligibility for SMCAA programs and programs administered by the CAA;
- Provide my contact information to other state, federal, and local government entities and not for profit agencies for the purpose of notifying me of other programs administered by such government entities and not for profit agencies;
- Provide information to and obtain information from the agencies listed above or others as needed to determine and confirm eligibility for SMCAA programs and programs administered by the CAA; and
- Disclose my personal information for the determination of eligibility for programs administered by state, federal, and local agencies.

I also grant permission to state and federal agencies to share my personal information relevant to application for SMCAA programs. I understand this information may include the benefits I received.

I specifically grant permission to the Michigan Department of Health and Human Services, the Michigan Department of Labor, and the Social Security Administration, and their successor agencies, to share my personal information, including benefits received, relevant to application for SMCAA program and other SMCAA programs.

<b>Printed Name</b>	<b>Social Security Number</b>
<b>Signature</b>	<b>Date</b>
<b>Printed Name</b>	<b>Social Security Number</b>
<b>Signature</b>	<b>Date</b>
<b>Printed Name</b>	<b>Social Security Number</b>
<b>Signature</b>	<b>Date</b>
<b>Printed Name</b>	<b>Social Security Number</b>
<b>Signature</b>	<b>Date</b>

I give consent for one (1) year for SMCAA staff to refer my name to other SMCAA programs or to other agencies for services that I may be eligible. I further agree to allow SMCAA staff to verify any information vital to determine eligibility and provision of services.

Primary Applicant Signature	Date
-----------------------------	------

