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# Southwest Michigan Community Action Agency

HELPING PEOPLE. CHANGING LIVES
Serving Berrien, Cass, and Van Buren Counties

## Release of Information Form

**CAA Name:** Southwest Michigan Community Action Agency **CAA Phone:** 269-925-9077 **CAA Fax:** 269-934-8242
**CAA Address:** 185 E. Main St, Suite 303 **CAA Email:** contact@smcaa.com
Benton Harbor, MI 49022 **CAA Website:** www.smcaa.com

**Applicant Name:** _____
**Physical Address:** _____ **Date of Application:** _____
**City/State/Zip:** _____

**Instructions:** *All household members 18 years old or older 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.

_____ _____
Printed Name Social Security Number

_____ _____
Signature Date

_____ _____
Printed Name Social Security Number

_____ _____
Signature Date

_____ _____
Printed Name Social Security Number

_____ _____
Signature Date

_____ _____
Printed Name Social Security Number

_____ _____
Signature Date

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

*If the applicant declines to sign this release, a denial of service will be issued.*