

Michigan's Coordinated Access to Food for the Elderly (MiCAFE)

A program of Elder Law of Michigan, Inc.
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Authorization and Consent to Release Information

By participating in the MiCAFE program and signing this document, I authorize the MiCAFE program to access, release, and use my personal information as directed below.

A. Use of the information

The information is to be used for the following purposes only:

1. To help me obtain benefits using the MiCAFE program;
2. To advocate on my behalf

B. Information Included

I authorize the following information about me to be accessed and used:

1. Personal identifying information, including: my name, social security number, address, and date of birth;
2. Information about my monthly income, shelter costs, medical expenses, and assets;
3. Information regarding public benefits that I am currently receiving, or have received in the past, including: my case number, the amount, and type of benefits I receive, and timeframe that I am eligible to receive the benefits;
4. Any information necessary to help obtain benefits using the MiCAFE Program and to advocate on my behalf.

C. Source of Information

The information that will be accessed and used will be obtained from the following sources:

1. The application that I completed with the MiCAFE program;
2. The Michigan Department of Health and Human Services;
3. Any other state or federal agency that has collected the information outlined in Section B.

D. Sharing of Information

I authorize the information that will be accessed and used to be shared with the following agencies in order to carry out the purposes outlined in Section A:

1. MiCAFE staff employed by Elder Law of Michigan, Inc. located in Lansing, Michigan;
2. The volunteer that assisted me through MiCAFE;
3. Agency staff at the MiCAFE site where I applied;
4. Michigan Department of Health and Human Services staff.

E. Understanding of Confidentiality

I understand that MiCAFE and its host organization, Elder Law of Michigan, will not share any information about me without my permission. Any information I provide will be kept in the strictest of confidences. None of the information exchanged will be discussed outside of the MiCAFE appointment and benefit eligibility determination process except as authorized above.

By signing my name below, I certify that I have read this consent form or someone has read it to me. This consent will be effective unless and until I end it in writing signed by me.

Printed Name: _____ Date: _____

Signature: _____ Agency Witness: _____