UPHP - UPCAP
CARE MANAGEMENT PROGRAM
Consent & Authorization

I, _____, am voluntarily participating in the UPHP MI Health Link Home and Community-Based Waiver Program. As such, I have been informed of my rights and obligations, and understand the purpose of the information I have or will provide to the program's UPCAP Care Managers. I also understand that this information is private and confidential, true and accurate to the best of my knowledge. I further agree to notify UPCAP Care Management if my needs change or problems arise, such as hospitalization.

By my voluntary participation in UPHP MI Health Link Home and Community Based Services, I agree to "Hold Harmless" UPCAP Care Management and its Care Managers from the errors and omissions of others.

AUTHORIZATION TO RELEASE INFORMATION

I AUTHORIZE, through my signature below, any Physician, medical practitioner, attorney, hospital, clinic, Social Security Administration, Michigan Department of Health and Human Services, Public Health, Private Home Health Agency, Community Mental Health Agency, Banking institution, and/or other medical or medically related facility, insurance or reinsuring company having information available as to diagnosis, treatment, or prognosis, with respect to any physical or mental condition, treatment, and/or financial information, to give the UPCAP Care Managers any and all such information. This information includes, but is not limited to, information related to medical condition, medications, treatment, financial plans, and/or service arrangements and plans. I also authorize UPCAP Care Managers to share with any of the above noted entities information it has obtained from me in order to assist me to remain in my home environment or for Medicaid or other benefit determination (or redetermination) purposes.

I UNDERSTAND that the information obtained by this authorization will be used by UPCAP Care Managers to determine eligibility for benefits available through the Federal Home and Community-Based Waiver and/or other entitlement programs for which I may be eligible.

I FURTHER UNDERSTAND that any information shared by the UPCAP Care Managers will be used by those agencies to better assist with the service provision of these agencies, and that such agencies and UPCAP Care Management will maintain such information in a confidential manner as prescribed by law.

I ACKNOWLEDGE that I have received a copy of this authorization and understand that the authorization will automatically expire one year from the date of my signature.

Signed this _____ day of _____, 20 _____.

Name of Client: _____

Signature of Client

UPHP - UPCAP
CARE MANAGEMENT PROGRAM
Consent & Authorization

*** * * * * SPOUSE AUTHORIZATION * * * * ***

I authorize UPCAP Care Managers to obtain and share information needed to determine eligibility for benefits.

Signature of Spouse: _____

INFORMATION REQUESTED

_____ SOCIAL SECURITY ADMINISTRATION: _____
_____ HOSPITAL MEDICAL RECORD(S): _____
_____ PHYSICIAN – DIAGNOSIS & H&P: _____
_____ INSURANCE INFORMATION: _____
_____ BANKING INSTITUTION: _____
_____ MDHHS: _____
_____ _____: _____

_____ _____
CM Signature Date

Please send to: UPCAP Care Management
(CONSENT)