BAY AREA CAPI CONSORTIUM
CAPI PROCESSING CENTER
1487 Huntington Ave
South San Francisco, CA 94080
1-800-648-0954

Alameda*Contra Costa*Marin*Merced*Monterey*Santa Cruz*San Mateo*Solano*Sonoma*Stanislaus

Case Number (optional): _____

I, _____ appoint the individual(s) named below to act as my authorized representative(s) to accompany, assist, and represent me in my application for, or redetermination of, CAPI benefits.

You are hereby authorized to release and discuss all information and documents regarding my CAPI eligibility with the individual(s) named below. I may terminate this authorization at any time by contacting the Human Services Agency.

My authorized representative(s) is/are:

_____ _____ _____
Name of Authorized Representative *Phone Number* *Relationship to Client/Name of Organization*

_____ _____ _____ _____
Address of Authorized Representative *City* *State* *Zip Code*

_____ _____ _____
Name of Authorized Representative *Phone Number* *Relationship to Client/Name of Organization*

_____ _____ _____ _____
Address of Authorized Representative *City* *State* *Zip Code*

For release of Medical information, this form must be signed by the client <u>AND</u> the Authorized Representative.

_____ _____ _____
***Print** Name of Authorized Representative* *Phone Number* *Signature of Authorized Representative*

_____ _____ _____ _____
Address of Authorized Representative *City* *State* *Zip Code*

Note: This form must be signed in the presence of a county employee.

_____ _____ _____
Client Signature *Phone Number* *Date*

_____ _____ _____ _____
Client Address *City* *State* *Zip Code*

_____ _____ _____
***Print** County Employee Name and Title* *County Employee Signature* *Date*