



MMAP
MICHIGAN MEDICARE
ASSISTANCE PROGRAM
Navigating Medicare

Acknowledgment and Authorization for Background Check

I acknowledge receipt of the stand-alone Notice Regarding Background Check and certify that I have read and understand the Notice Regarding Background Check and Acknowledgment and Authorization for Background Check. I hereby authorize the obtaining of “consumer reports” and/or “investigative consumer reports” by **MMAP, Inc.** at any time after receipt of this authorization and throughout my time of service with the Michigan Medicare/Medicaid Assistance Program (MMAP).

To this end, I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or insurance company to furnish any and all background information requested by: **IntelliCorp Records, Inc., 3000 Auburn Dr., Suite 410, Beachwood, Ohio 44122: Tel. No. 1-888.946.8355; www.intellicorp.net.**

I consent to have any legally required notices sent to me electronically to the email address listed below.

Please Print:

Last Name _____ First _____ Middle _____

Other names you may either be or have been known by, within the last 7 yrs. (maiden name, birth name, nicknames, etc.)

Address _____
Number and street City Zip code

Social Security No. _____ Date of Birth** _____

***This information will be used for background screening purposes only and will not be used as selection criteria.*

Email: _____

Signature: _____ Date: _____

Print Name: _____

Fax to: 517-886-1305 or mail to MMAP, Inc. Ste. 204. 6105 W. St. Joseph Hwy. Lansing, MI48917