BHSF Form AR
Rev. 11/03
II

MEDICAID PROGRAM
Consent for Authorized Representation

Name of Applicant/Recipient	SSN	Case ID Number

I understand that all information gathered on my situation and those persons for whom I am legally responsible is personal and confidential. My decision to appoint an Authorized Representative is optional, made freely and does not relieve me of my responsibility to actively participate in the Medicaid eligibility process. I understand that the function of the Authorized Representative is to accompany, assist, and represent me in the eligibility determination process, and to aid in obtaining financial, medical and/or other documentation necessary for the agency's determination of my initial or continuing eligibility for Medicaid.

I understand that this authorization is limited to the individual(s) named below; is valid **only** for my Medicaid application or renewal form dated _____; and will automatically terminate on the date of the agency's decision regarding my initial or continuing eligibility. I also understand that I may cancel my appointment of the individual(s) named below as my Authorized Representative at any time prior to the automatic expiration.

I understand that while some of the information gathered may have no impact on my Medicaid eligibility, it may affect my liability to a third party should this information be disclosed to the third party by my Authorized Representative. I hereby hold the Department of Health and Hospitals harmless for any claim resulting from disclosure of information to a third party by my Authorized Representative.

I understand that if this authorization is not signed in the presence of agency staff or a program representative, a confirmation of authenticity may be conducted by agency staff.

Name of Authorized Representative	( ) Phone
Name of Authorized Representative	( ) Phone
Signature of Applicant/Recipient	Date

If Signed by an "X"

Signature of Witness	Date

White Copy – Agency Yellow Copy - Applicant/Recipient

For Agency Use ONLY

On _____ (MM/DD/YY), the applicant or recipient was contacted to verify the authorization provided on the reverse side of this form.

The authorization ❑ **is** ❑ **is not** valid.

_____ _____

Date Agency Representative