Authorized Representative Form

For use with Medicaid applications

Applicant Name **Date**

Case Number **Date of Birth**

Home Address

Mailing Address

Phone Number **Email**

This form is used to designate an authorized representative to act on your behalf for Medicaid certification and reporting purposes. Your representative may be an adult individual, a company, or an organization.

Complete all applicable sections, including representative contact information and scope of authority. Submit this completed form to the Medicaid office in person, by mail, or by email. Be sure to have the appropriate identification documents present at the time of submission.

Required Documentation:

- Authorized Representative must provide a Picture ID
- Authorized Representative must provide an executed and notarized Power of Attorney
- Social Security Card

The client and/or authorized representative may revoke this authorization at any time by providing a written statement to the Medicaid office.

Authorization of Representative:

I, , understand that I have the right to designate an adult as my authorized representative for Medicaid purposes. I hereby designate the following individual (or entity) to act on my behalf for certification and/or reporting purposes with the understanding that I would be held liable for any issuance resulting from false information given by them.

Applicant Name **Relationship to Client**

Home Address

Phone Number **Email**

FOR OFFICE USE ONLY
Received by: Date

Scope of Authorization (check all that apply):

- ☐ Sign an application on the applicant's behalf;
- ☐ Complete and submit a renewal form;
- ☐ Receive copies of the applicant or beneficiary's notices and other communications from the agency;
- ☐ Act on behalf of the applicant or beneficiary in all other matters with the agency.

Client Signature _____ **Date** _____

Client Perjury Statement:

Under penalty of perjury, I certify that the information presented in this document is true and accurate to the best of my knowledge. By signing below, I understand that providing false statements may result in termination, denial, or recovery of benefits.

Client Printed Name _____ **Date** _____

Client Signature _____

OR

Auth Rep Signature _____ **Date** _____

Phone Number _____ **Email** _____

Acceptance of Representative:

I, _____, understand that as an authorized representative I may act on the individual's behalf for Medicaid certification and reporting purposes upon submission of this completed form. I agree to maintain the confidentiality of any information regarding the applicant or beneficiary provided by the agency.

Auth Rep Signature _____ **Date** _____

Mailing Address _____

Phone Number _____ **Email** _____