DESIGNATION OF AUTHORIZED REPRESENTATIVE

____________________COUNTY

I____ give permission for
(Name of Applicant/Recipient) **Please Print**

____
(Name of Authorized Representative **Please Print**
and Relationship to the Applicant/Recipient)

____
(Address and Phone Number of Authorized Representative) **Please Print**

____
(Language Preference of Authorized Representative) **Please Print**

to act as an Authorized Representative in my behalf. This person knows my circumstances well enough to answer any questions for the Medicaid program purposes.

I understand I and my authorized representative are responsible for incorrect or incomplete information provided.

I understand that signing this form gives my representative authority to:

1. Make an application or complete a redetermination of eligibility for Medicaid for me;
2. Sign any forms necessary to determine my eligibility for Medicaid;
3. View and/or discuss any information contained in my file (other than information from another source specifically designated as "Confidential" or "Do Not Release") or concerning my case to determine eligibility for assistance.

I understand that I may revoke this designation of Authorized Representative at any time.

____
Applicant/Recipient Signature DATE

____
Authorized Representative Signature DATE

DMA-5018