AUTHORIZED REPRESENTATIVE FOR HEALTH COVERAGE

State Form 55366 (R / 10-13) / DFR 2123HC

DFRAZAE01

Section 1

If you want someone to act on your behalf in applying for benefits and/or act for you on an ongoing basis, this form must be completed. Be sure to select the function(s) that the representative is being authorized to do. You can select more than one representative and choose the same or different functions. Complete ONE form per authorized representative. Both you and your representative must sign and date this form.

Section 2

Name of Representative (*Please print clearly*):

Check association with applicant/recipient. *Please select ONE (1).*

☐	Attorney	☐	Eligibility Assistance Company	☐	Friend	☐	Family
☐	Institution of Residence	☐	Waiver Case Manager	☐	Other (*Specify*): _____		

Mailing Address (*number and street, city, state, and ZIP code*):

SELECT THE FUNCTION(S) THE AUTHORIZED REPRESENTATIVE WILL DO:

FUNCTION	FUNCTION DESCRIPTION	HEALTH COVERAGE
APPLY	• Sign application and be interviewed. • Provide all required proof of information necessary to determine eligibility for benefits. • Receive the Notice of the application decision. • Speak on applicant's behalf at a hearing if the application decision is appealed.	**Apply** ☐
ONGOING	• Report changes. • Attend periodic redeterminations. • Receive the appointment notices and any redetermination mail-in forms. **NOTE:** Do not check this function if the representative will not continue to act on recipient's behalf after the application decision is made.	**Ongoing** ☐

In agreeing to be the authorized representative, I understand that I am expected to be knowledgeable of the applicant's/recipient's circumstances and that this authorization can be revoked by the applicant/recipient at any time.

Signature:	Date (*mm/dd/yyyy*):	Telephone ((###) ###-####):

Section 3

I authorize this representative to act for me in taking care of the functions and program eligibility process which I have checked above. (If applicant/recipient is medically incapable to sign authorization, provide medical documentation.) I understand that I am responsible for the information anyone acting as my authorized representative gives, including any information that may be incorrect. I also understand that if at any time I wish to stop the person(s) I chose from being my authorized representative, it is my responsibility to contact the Division of Family Resources.

Applicant/Recipient Name	Applicant/Recipient Signature	Date (*mm/dd/yyyy*):

Case Number (*Optional*):