SUPPLEMENTAL INFORMATION

Designation of Authorized Representative Form

NJ FAMILYCARE
Affordable health coverage. Quality care.

STATE OF NEW JERSEY
Department of Human Services
Division of Medical Assistance and Health Services

DESIGNATION OF AUTHORIZED REPRESENTATIVE FORM

I, _____ hereby authorize the following person or company to be
(Name of Applicant)
my Authorized Representative in my application for Medicaid filed with the Eligibility Determining Agency (EDA) or New Jersey Division of Medical Assistance and Health Services (DMAHS) and in all review of my eligibility. I authorize my representative to take any action which may be necessary to establish my eligibility for NJ FamilyCare.

Name of Representative: _____

Company: _____

Address: _____

City, State, Zip: _____

Phone Number: (____ ____ ____) ____ ____ ____ - ____ ____ ____ ____

_____ initial
My decision to appoint an Authorized Representative is voluntary and made freely. I understand that signing this document does not relieve me of my responsibility to participate in the NJ FamilyCare eligibility process, including providing information and documents.

_____ initial
I understand that as a result of this authorization, the DMAHS and the applicable EDA may disclose and release information to the Authorized Representative including my Social Security number, financial statements, medical information and the reasons for denial.

_____ initial
I have been fully informed in writing by the Authorized Representative of actual or potential conflicts of interests that may exist between the above named entity and me. I hereby waive any conflict of interest. If there is no conflict of interest, the Authorized Representative has also put that in writing.

_____ initial
I understand that the information shared with Authorized Representative may affect my liability to a third party, include the Authorized Representative and may be disclosed to others. I hereby hold DMAHS and the EDA harmless for any claim or action resulting from the use or disclosure of information by my Authorized Representative.

SIGN ON BACK

Signatures

_____ initial — I understand that I may revoke this authorization at any time by notifying the Authorized Representative and the EDA in writing.

_____ initial — I understand that while this authorization is in effect, all notices/correspondence sent by DMAHS and the applicable EDA will only be sent to the Authorized Representative.

_____ initial — I understand that neither the State of New Jersey nor the EDA charge a fee to file a NJ FamilyCare application.

_____ Signature of NJ FamilyCare Applicant or Person Granting Authority

_____ Date (mm/dd/yyyy)

_____ Relationship (Self, Guardian, etc.)

_____ Witness

_____ Date (mm/dd/yyyy)

_____ Print Name

_____ Signature of Authorized Representative

_____ Title (if employee of authorized company)

_____ Print Name

_____ Date (mm/dd/yyyy)

_____ Witness

_____ Date (mm/dd/yyyy)

_____ Print Name

This form has no effect unless witnessed and signed by the person granting authority and by the Authorized Representative or an agent of the company appointed to be the Authorized Representative.

NJFC-AUTH-0217