



## State of New Jersey

DEPARTMENT OF HUMAN SERVICES  
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

P.O. Box 712  
Trenton, NJ 08625-0712

CHRIS CHRISTIE  
*Governor*

JENNIFER VELEZ  
*Commissioner*

KIM GUADAGNO  
*Lt. Governor*

VALERIE HARR  
*Director*

**MEDICAID COMMUNICATION NO. 11- 03      DATE: February 22, 2011**

**TO:            County Welfare Agency (CWA) Directors  
                 Institutionalized Services Section (ISS) Area Supervisors**

**SUBJECT:    Medicaid Designation of Authorized Representative Form**

In an effort to protect New Jersey residents and expedite the application process, the Division of Medical Assistance and Health Services (DMAHS) has issued an authorization form to be used when an applicant or recipient wishes to have someone apply on their behalf. The utilization of this form will assure the authorizations are complete and consistent throughout the State. Enclosed is a copy of the form for your convenience.

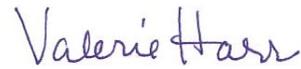
This form must be used when an applicant or guardian of the applicant consents to the appointment of a representative who is not a family member. This form is not required if the applicant has retained a lawyer. This form is also not required if the authorized representative is the court appointed guardian or power of attorney. In such cases, the legal documentation must be submitted to the County Welfare Agency/ Institutionalized Services Section (CWA/ISS).

Each paragraph must be initialed by the applicant or the person authorized to act on behalf of the applicant. In addition, the signature of the Medicaid applicant or person with legal authority and the signature of the authorized representative must be witnessed. This form does not relieve the applicant of his/her responsibility in obtaining documentation or cooperating with the CWA/ISS in completing the application.

The form will be located on the Department of Human Services' website at <http://www.state.nj.us/humanservices/dmahs/news/>.

If you have any questions regarding this Medicaid Communication, please refer them to the Division's Office of Eligibility Policy field service staff for your agency at 609-588-2556.

Sincerely,



Valerie Harr  
Director

VH:ej  
Attachment

c: Jennifer Velez, Commissioner  
Department of Human Services

Kevin Martone, Deputy Commissioner  
Department of Human Services

Joseph Amoroso, Acting Director  
Division of Disability Services

Jeanette Page-Hawkins, Director  
Division of Family Development

Dawn Apgar, Acting Assistant Commissioner  
Division of Developmental Disabilities

Allison Blake, Commissioner  
Department of Children and Families

Poonam Alaigh, M.D., Commissioner  
Kathleen M. Mason, Assistant Commissioner  
Patricia Polansky, Assistant Commissioner  
Department of Health and Senior Services

**NEW JERSEY MEDICAID PROGRAM**

**DESIGNATION OF AUTHORIZED REPRESENTATIVE**

\_\_\_\_\_ (Name of Applicant) hereby authorizes the following person or company to be my Authorized Representative in my application for Medicaid filed with the County Welfare Agency (CWA) or New Jersey Division of Medical Assistance and Health Services (DMAHS) Office of Institutional Services (ISS) and in all reviews of my eligibility. I authorize my representative to take any action which may be necessary to establish my eligibility for Medicaid.

Name of Representative:

Company:

Address:

City:

State:

Zip

Phone Number:

\_\_\_\_\_ 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 Medicaid eligibility process, including providing information and documents.

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

\_\_\_\_\_ 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.

\_\_\_\_\_ I understand that the information shared with Authorized Representative may affect my liability to a third party, including the Authorized Representative and may be disclosed to others. I hereby hold DMAHS and the CWA/ISS harmless for any claim or action resulting from the use or disclosure of information by my Authorized Representative.

\_\_\_\_\_ I understand that I may revoke this authorization at any time by notifying the Authorized Representative and the CWA/ISS in writing.

\_\_\_\_\_ I understand that while this authorization is in effect, all notices /correspondence sent by DMAHS and the applicable CWA/ISS will only be sent to the Authorized Representative.

\_\_\_\_\_ I understand that neither the State of New Jersey nor the County Welfare Agency charge a fee to file a Medicaid application.

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.

Signature of Medicaid Applicant or  
Person Granting Authority:

\_\_\_\_\_

Date: \_\_\_\_\_

\_\_\_\_\_  
Relationship (Self, Guardian etc.)

Witness \_\_\_\_\_

Date \_\_\_\_\_

Print Name: \_\_\_\_\_

\_\_\_\_\_  
Signature of Authorized Representative

\_\_\_\_\_  
Title (if employee of authorized company)

\_\_\_\_\_  
Print Name

Date \_\_\_\_\_

Witness \_\_\_\_\_

Date \_\_\_\_\_

Print Name: \_\_\_\_\_