

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

DESIGNATION OF AUTHORIZED REPRESENTATIVE FORM

| l, | hereby authorize t (Name of Applicant) | he following: | person or company to be |
|------------------------|--|------------------------------|--|
| Agency (E review of | orized Representative in my application for Medical EDA) or New Jersey Division of Medical Assistance a f my eligibility. I authorize my representative to tak lish my eligibility for NJ FamilyCare. | ind Health Se | rvices (DMAHS) and in all |
| Name | e of Representative: | | |
| Compa | oany: | | |
| Addres | PSS: | | |
| City: | | State: | Zip: |
| Phone | e Number:(area code) | | |
| 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 my liability to a third party, include the Author closed to others. I hereby hold DMAHS and the resulting from the use or disclosure of information. | rized Represo EEDA harmle | entative and may be dis- ss for any claim or action |

Signatures

| initial | I understand that I may revoke this authorization at any time by notifying the Authorized Representative and the EDA in writing. 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 | | | |
| initial | I understand that neither the State on NJ FamilyCare application. | of New Jersey nor the EDA charge a fee to file a | |
| | e of NJ FamilyCare Applicant n Granting Authority | Date (mm/dd/yyyy) | |
| Relations | ship (Self, Guardian, etc.) | | |
| Witness | | Date (mm/dd/yyyy) | |
| Print Nan | me | | |
| Signature of Authorized Representative | | Title (if employee of authorized company) | |
| Print Name | | Date (mm/dd/yyyy) | |
| Witness | | Date (mm/dd/yyyy) | |
| Print Nan | me | | |

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.