

AUTHORIZED REPRESENTATIVE FORM

CLIENT'S NAME: _____ **DATE OF BIRTH#:** _____
SSN: _____ **CASE NUMBER:** _____

AREA CODE AND DAYTIME PHONE NUMBER: (_____) _____

I WISH TO APPEAL THE DECISION OF _____ TO
Name of Agency
DENY, TERMINATE, OR REDUCE MY MEDICAID OR FAMIS BENEFITS. THE
ACTION WAS TAKEN ON _____.
Date

I HEREBY APPOINT _____ AS MY AUTHORIZED
REPRESENTATIVE TO ACT ON MY BEHALF DURING MY MEDICAID/FAMIS
APPEAL.

MY REPRESENTATIVE'S ADDRESS IS: _____

MY REPRESENTATIVE'S AREA CODE AND DAYTIME TELEPHONE NUMBER ARE
(_____) _____.

I UNDERSTAND THAT I HAVE THE RIGHT TO REFUSE TO SIGN THIS
AUTHORIZATION AND THAT IT IS STRICTLY VOLUNTARY.
I UNDERSTAND THAT MY SIGNATURE DOES NOT WAIVE MY RIGHT TO
REPRESENT MYSELF.
I UNDERSTAND THAT MY SIGNATURE DOES NOT WAIVE MY FINANCIAL
OBLIGATION SHOULD THE APPEAL BE DECIDED IN THE AGENCY'S FAVOR.
I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME IN
WRITING.

Print Name of Client/ /Parent of Minor Child

Signature of Client/ /Parent of Minor Child

Date

IF APPELLANT IS PHYSICALLY UNABLE TO SIGN, THE AUTHORIZED
REPRESENTATIVE MAY SIGN BELOW:

I hereby certify that _____ is physically unable to sign this authorized
representative form and in support of that I state as follows: _____

(Describe the physical incapacity affecting the appellant above)

Signature of Authorized Representative

**NOTE: If client is mentally incapable of signing the authorized representative
form, you must submit legal proof of guardianship with the appeal. This form is
not valid for clients who are mentally incapable of signing.**