

**DESIGNATION OF AUTHORIZED REPRESENTATIVE FOR HOME CARE ATTENDANT SERVICES**

Medicaid Billing # or SSN			
Consumer First Name	MI	Last Name	County of Residence
Mailing Address		City	State      Zip Code
<b>I hereby authorize the following individual to represent me regarding <i>Home Care Attendant Services</i>:</b>			
First Name	MI	Last Name	
Title	Home or Cell Phone		Work Phone
Mailing Address		City	State      Zip Code
This authorization lasts until (mm/dd/yyyy)			
<b>I authorize this individual to do the following on my behalf:</b>			
<input type="checkbox"/> Take any action that may be needed to ensure that I receive or continue to receive Home Care Attendant Services.			
<b>- OR -</b>			
<input type="checkbox"/> Only perform the specific actions described below.			
1. _____		5. _____	
2. _____		6. _____	
3. _____		7. _____	
4. _____		8. _____	
<b><u>SIGNATURES</u></b>			
<b>This form has no effect unless signed by the consumer granting authority and by the individual appointed to be the authorized representative.</b>			
Printed Name of Consumer Granting Authority		Signature of Consumer Granting Authority	Date
Printed Name of Authorized Representative		Signature of Authorized Representative	Date

**NOTE:** *A separately executed HIPAA Authorization is required if the authorized representative requires access to any information in the consumer's Medicaid case.*