Ohio Department of Medicaid

DESIGNATION OF AUTHORIZED REPRESENTATIVE

First Name of Applicant/Recipient	MI	Last Name		Medicaid billing # or SSN
Street Address, including Apt. #		City	Zip	County

I hereby authorize the following person or company to act as my representative:

First Name	MI	Last Name	Home Phone	
Title	Company		Work Phone	
Mailing Address		City	State	Zip

I authorize this person or company to represent me regarding:

☐ Food Assistance ☐ Cash Assistance ☐ Medicaid ☐ Child Care

This authority lasts until:

☐ My application has been approved
☐ I rescind this authority, or appoint a new representative
☐ Other (please specify a date or action) _____

I authorize this person or company to do the following on my behalf:

☐ Take any action that may be needed to ensure that I receive or continue to receive the benefits indicated above

OR only the specific actions selected below

☐ Present my application for benefits
☐ Represent me at a state hearing
☐ Provide verifications to the CDJFS on my behalf
☐ Collect my medical records
☐ Receive and respond to copies of all correspondence regarding my application
☐ Other (please specify) _____

While this authorization is in effect, all notices sent by the County Department of Job & Family Services or the Ohio Department of Medicaid will also be sent to your authorized representative.

Signatures. This form has no effect unless signed by the person granting authority and by the authorized representative or an employee of the company appointed to be the authorized representative.

Signature of Person Granting Authority		Date
Signature of Authorized Representative	Title *(if employee of authorized company)*	Date