Lorain County Department of Job and Family Services

DESIGNATION OF AUTHORIZED REPRESENTATIVE

Case Number _____

First Name of Applicant/Recipient	MI	Last Name	Medicaid billing # or SSN
Street Address, including Apt #	City	Zip	County #47 / LORAIN
Client Telephone Number (required for DDA)	**Client Recipient Number (required for DDA)**		

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
☐ Other - list:

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
☐ Provide verifications to the CDJFS on my behalf
☐ Represent me at a state hearing
☐ Collect my medical records
☐ Protective Payee on my cash benefits
☐ To receive benefits on my behalf
☐ Receive and respond to copies of all correspondence regarding my application
☐ Discuss and receive information regarding my financial and medical information including protected health information. (PHI)
☐ 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 Job & Family Services 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. By signing below, the authorized representative agrees to maintain the confidentiality of any information regarding the applicant/recipient provided by the agency. If the authorized representative is a provider, staff member or volunteer of an organization, then the authorized representative also agrees to adhere to the regulations cited in 42 C.F.R. 43.923 (e).

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