SUPPLEMENTAL INFORMATION

Designation of Authorized Representative Form
DESIGNATION OF AUTHORIZED REPRESENTATIVE FORM

I, _________________________________________ hereby authorize the following person or company to be
(Name of Applicant)
my Authorized Representative in my application for Medicaid filed with the Eligibility Determining
Agency (EDA) or New Jersey Division of Medical Assistance and Health Services (DMAHS) and in all
review of my eligibility. I authorize my representative to take any action which may be necessary
to establish my eligibility for NJ FamilyCare.

Name of Representative: ____________________________________________________________________________
Company: ___________________________________________________________________________________________
Address: ____________________________________________________________________________________________
City, State, Zip: ______________________________________________________________________________________
Phone Number: (____ ____ ____) _____ _____ _____ - _____ _____ _____

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.

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.

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.

I understand that the information shared with Authorized Representative may affect
my liability to a third party, include the Authorized Representative and may be dis-
closed to others. I hereby hold DMAHS and the EDA harmless for any claim or action
resulting from the use or disclosure of information by my Authorized Representative.
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.

I understand that neither the State of New Jersey nor the EDA charge a fee to file a NJ FamilyCare application.

____________________________________________________________
Signature of NJ FamilyCare Applicant or Person Granting Authority

Date (mm/dd/yyyy)

Relationship (Self, Guardian, etc.)

____________________________________________________________
Witness

Date (mm/dd/yyyy)

Print Name

____________________________________________________________
Signature of Authorized Representative

Title (if employee of authorized company)

Print Name

Date (mm/dd/yyyy)

Witness

Date (mm/dd/yyyy)

Print Name

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.