Commonwealth of Kentucky
Cabinet for Health and Family Services
Department for Medicaid Services

Application Intake – Participant Authorization

Participant

- ☐ I understand that my medical information will be shared with the Commonwealth of Kentucky, and its contract employees, in order to be a participant in the Medicaid Waiver Program
- ☐ I consent that all of the information is correct
- ☐ I consent that the Application Initiator has the authority to apply on behalf of this person

First Name _____ Middle Initial _____ Last Name _____

Signature _____

Authorized Representative

Is the Authorized Representative applying on behalf of the individual?

- ☐ Yes
- ☐ No

First Name _____ Middle Initial _____ Last Name _____

Signature _____