MAP 14
(7/16)

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

I _____ have asked_____
(Print Your Name) **(Print Authorized Representative's Name)**

to help me as I have chosen below with Medicaid. This authorization is valid from the date of applicant's signature until the form is rescinded by the applicant.

I give my permission for the person named above as my authorized representative to (please check all that apply):

- ☐ **Submit an application for Medicaid benefits,**
- ☐ **Complete and submit any renewal forms,**
- ☐ **Receive copies of the applicant or members correspondence and notices,**
- ☐ **Act on behalf of the applicant or member in all other matters with DCBS or the Department for Medicaid Services**

I understand that I or my authorized representative must provide complete and truthful information to have my Medicaid eligibility determined or redetermined. My authorized representative is responsible for fulfilling all responsibilities designated above as well as agreeing to maintain the confidentiality of any information regarding the applicant or member provided by the agency.

If I or my authorized representative knowingly provides false information or withholds information I may be subject to prosecution for fraud.

Eligibility determinations may take up to 30 days from the date of application to be completed. All identification cards and letters will be mailed to the address you choose. You will need to show your identification card to your medical providers so they can bill Medicaid for the services you received.

Printed Applicant/Member Name	Printed Authorized Representative Name
Applicant/Member Signature	Authorized Representative Signature
Applicant/Member Address	Authorized Representative Address
City, State, Zip	City, State, Zip
Phone Number	Phone Number
Date Signed	Date Signed
Witness (if signed by X)	Relationship or Company Name