

MAP 14
(2/18)

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 This authorization is valid from the date of applicant's signature until the form is rescinded by the applicant.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):

- Apply, Report Changes**
- Apply, Report Changes, Recertify**
- Apply, Report Changes, Recertify and receive a copy of Notices**

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)

Email Address

Relationship or Company Name