MAP 14
(10/21)

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 This authorization is valid from the date of applicant's signature until the form is rescinded by the applicant.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

____
Applicant/Member Signature

____
Applicant/Member Address

____
City, State, Zip

____
Phone Number

____
Date Signed

____
Witness (if signed by X)

____
Printed Authorized Representative Name

____
Authorized Representative Signature

____
Authorized Representative Address

____
City, State, Zip

____
Phone Number

____
Date Signed

____
Email Address

____
Relationship or Company Name