AHCCCS
Arizona Health Care Cost Containment System

AUTHORIZED REPRESENTATIVE FORM

By signing below I, the customer, give permission for the person listed below as my representative to act on my behalf in the process of qualifying me for AHCCCS Health Insurance. I, therefore:

- Give permission for my representative to complete and sign my application.
- Give permission for my representative to provide any documents requested, including personal information.
- Give permission to my representative to sign on my behalf to permit other people, businesses, or agencies to give personal information about me to AHCCCS, including protected health information needed to determine if I am disabled or if I am medically eligible for the Arizona Long Term Care System (ALTCS).
- Agree to give information about my personal circumstances to my representative.
- Agree to allow my representative to assign all my rights to medical reimbursement claims to AHCCCS on my behalf.

By signing below I, the representative, agree to act on the customer's behalf. I also agree to:

- Provide only truthful and complete information under penalty of perjury.
- Fill in and sign needed forms.
- Obtain and give to AHCCCS all information needed to determine if the customer can qualify for AHCCCS Health Insurance such as the customer's Social Security number, income, assets, citizenship, residency, medical insurance, and information about the customer's spouse, minor children, and parents (if the customer is a minor child).
- Tell AHCCCS right away if the customer:
  - ✓ Has an increase or decrease in income;
  - ✓ Has an increase or decrease in assets;
  - ✓ Changes ownership of assets, including opening or closing financial accounts;
  - ✓ Has a change in address; or
  - ✓ Has a change in health insurance or the amount of premiums paid.

If I am determined eligible, this authorization will stay in effect until I or my representative tells you to stop it. This authorization will expire when my application for assistance through AHCCCS is withdrawn or denied, or when my eligibility for assistance through AHCCCS ends. However, this authorization will continue during any time while I am contesting my eligibility in an administrative hearing or court proceeding.

Customer/Legal Guardian	Representative
Name: Address: Phone: ( ) -	Name: Address: Phone: ( ) -

Signature of Customer/Legal Guardian	Date	Signature of Representative	Date

Signature of Witness (If signed with a mark)	Date	Signature of Witness (If signed with a mark)	Date