APPOINTMENT OF REPRESENTATIVE

SECTION I. TO BE COMPLETED BY APPLICANT/BENEFICIARY

Name	Case number *(optional)*	Date

I appoint this individual _____ / _____
Name of individual ***Name of organization***

_____
Complete address Telephone number

as my authorized representative to accompany, assist, and represent me in my application for, or redetermination of, Medi-Cal benefits.

THIS AUTHORIZATION ENABLES THE ABOVE NAMED INDIVIDUAL TO:

- submit requested verifications to the county welfare department;
- accompany me to any required face-to-face interview(s);
- obtain information from the county welfare department and from the State Department of Social Services, Disability Evaluation Division, regarding the status of my application;
- provide medical records and other information regarding my medical problems and limitations to the county welfare department or the State Department of Social Services, Disability Evaluation Division;
- accompany and assist me in the fair hearing process; and
- receive one copy of a specific notice of action from the county welfare department, at the request of the applicant/beneficiary.

I UNDERSTAND THAT I HAVE THE RESPONSIBILITY TO:

- complete and sign the Statement of Facts;
- attend and participate in any required face-to-face interview(s);
- sign MC 220 (Authorization for Release of Medical Information);
- provide all requested verifications before my Medi-Cal eligibility can be determined; and
- accept any consequences of the authorized representative's actions as I would my own.

I UNDERSTAND THAT I HAVE THE RIGHT TO:

- choose anyone that I wish to be my authorized representative;
- revoke this appointment at any time by notifying my Eligibility Worker; and
- request a fair hearing at any time if I am not satisfied with an action taken by the county welfare department.

Applicant/Beneficiary's signature	Date
➤	

Address

SECTION II. TO BE COMPLETED BY THE AUTHORIZED REPRESENTATIVE NAMED. ***LAW FIRMS, ORGANIZATIONS, AND GROUPS MAY REPRESENT THE APPLICANT/BENEFICIARY BUT AN INDIVIDUAL MUST BE DESIGNATED AS THE CONTACT PERSON TO ACT ON THE APPLICANTS/BENEFICIARIES BEHALF.***

I HEREBY ACCEPT THE ABOVE APPOINTMENT AND UNDERSTAND THAT:

- the applicant/beneficiary may revoke this authorization at any time and appoint another individual(s) to act as his/her authorized representative;
- I have no other power to act on behalf of the applicant/recipient, except as stated above;
- I may not act in lieu of the applicant/beneficiary; and
- I may not transfer or reassign my appointment without a new Appointment of Representative form being completed by the applicant/recipient.

I CERTIFY THAT:

- I have not been suspended or prohibited from practice before the Social Security Administration
- I am not, as a current or former officer or employee of the United States, disqualified from acting as the applicant's representative; and
- I am known to be of good character.

This authorization is recognized for one year from the date signed by the applicant unless revoked earlier as described in Section 1 above.

Authorized representative's signature	Employed by	Date	Telephone number
➤			

COUNTY USE ONLY

_____ _____ _____
Date verbal request to revoke received Date written request to revoke received Request received from:

EW name: _____ Telephone number: _____