MCAP AUTHORIZED REPRESENTATIVE FORM

Applicant's Name: _____

Family Member Number: _____

I appoint as my Authorized Representative: _____
Name of Individual or Organization

_____
Individual's or Organization's Address

I authorize the above named individual or organization to act as my authorized representative as specified below, effective the date that this form is signed (check all that apply).

As my authorized representative to act on my behalf regarding my Medi-Cal Access Program (MCAP) application (only effective until a determination is made on my eligibility for MCAP benefits).

As my authorized representative to act on my behalf regarding all matters relating to my eligibility for and enrollment in the MCAP program except for appeals.

As my authorized representative to act on my behalf regarding all matters relating to my MCAP appeal.

As my authorized representative to act on my behalf for the following purposes (specify for what purpose(s) you want the authorized representative appointed or attach a document describing those purpose(s)):

_____

_____

_____

This appointment authorizes the above named individual or organization to accompany, assist and represent me as designated above.

I authorize the above named individual or organization to receive the following MCAP communications, effective the date that this form is signed (check all that apply).

All communications regarding my MCAP application (only effective until a determination is made on my eligibility for MCAP benefits).

All communications regarding my eligibility for and enrollment in the MCAP program.

All communications regarding my MCAP appeal.

[¯ The following communications regarding my enrollment in the MCAP program (specify what MCAP communications you want the authorized representative to receive or attach a document describing those communications):

_____

_____

_____

I understand that:

- This authorized representative designation may be cancelled or changed by me at any time by notifying MCAP.
- My authorized representative may cancel his/her/its appointment as my authorized representative at any time.
- My responsibilities have not been changed by my appointment of an authorized representative and that I am still responsible for making sure that all information, verifications and responses required by MCAP are timely provided.
- I must accept any consequences of the authorized representative's actions as I would my own.
- I have the right to choose anyone that I wish to be my authorized representative.

By checking this box and signing below, I acknowledge that I have appointed an organization as my authorized representative, and that any individual from that organization who has a MCAP Authorized Representative Standard Agreement on file with MCAP may perform the actions authorized on my behalf.

Applicant's Signature: _____Date:_____

The below is to be signed only if appointing an individual as your Authorized Representative

Authorized Representative Signature:_____Date:_____

Fax or mail this form to:

Fax number: 1-888-889-9238

Medi-Cal Access Program
P.O. Box 15559
Sacramento, CA 95852-0559

If you have questions, please call MCAP at 1-800-433-2611, Monday through Friday, 8:00 a.m. to 8:00 p.m., or on Saturday, 8:00 a.m. to 5:00 p.m. The call is free.