Cuyahoga Job and Family Services
Designation of Authorized Representative Form

Section 1 (Please print) Case Number

Name of Applicant	Medicaid Billing Number or SSN	County	
Street Address (Include Apt. #)	City	State	Zip

I hereby authorize the following person or entity to act as my representative.
This authority lasts until or until it is revoked by me in writing.

Name of Representative	Title	Company	
Home Phone	Work Phone	Email Address	
Mailing Address	City	State	Zip

I authorize my representative to do the following on my behalf:

☐ Act on my behalf in all matters with the agency ("agency" includes Cuyahoga Job and Family Services, the Ohio Department of Medicaid (ODM) and ODM's contracted designees). ***Note: If applying for SNAP benefits, please see the optional SNAP EBT Card Authorizations below.**

OR

I authorize my representative to do only the specific actions selected below:

☐Assist with my application/renewal for benefits
☐Provide verifications to the CDJFS on my behalf
☐Represent me at a state hearing
☐Receive and respond to copies of all correspondence
☐Discuss and receive information regarding my financial and medical information including protected health information (PHI) *
☐Other (Please specify)

***NOTE** *You must complete section 2 of this form if this authorization is intended to allow the use or disclosure of PHI.*

I authorize my representative to act on my behalf in all business related to the following assistance program:

☐**ALL PROGRAMS** ☐OWF/TANF (Cash Assistance) **NOTE:** If no selection is made, we will assign the authorized representative for all programs.
☐ SNAP (Food Assistance) ☐ Medicaid

OPTIONAL: SNAP EBT Card Authorization – I authorize my representative to act my behalf to:

☐ Obtain a SNAP benefits EBT card on behalf of my assistance group.
☐ Use a SNAP benefits EBT card on behalf of my assistance group.

While this authorization is in effect, all notices sent by the CDJFS and/or ODM will also be sent to your authorized representative.

Signatures: This form has no effect unless signed by both the person granting authority and by the authorized representative. By signing below, the authorized representative agrees to maintain the confidentiality of any information regarding the applicant/recipient provided by the agency. If the authorized representative is a provider, staff member or volunteer of an organization, then the authorized representative also agrees to adhere to the regulations cited in 42 C.F.R. 435.923(e).

Signature of Person Granting Authority *(Applicant/Recipient or Parent/Guardian)*		Date
Signature of Authorized Representative	Title (if employee of an organization)	Date

Section 2

Authorization for the Use and Disclosure of Protected Health Information

Name of Applicant/Recipient	Case Number/Medicaid ID		Date of Birth
Address	City	State	Zip Code

Cuyahoga Job and Family Services (CJFS), the Ohio Department of Medicaid (ODM) and ODM's contracted designees (*including Medicaid managed care plans*) are authorized to disclose my protected health information (PHI) to my authorized representative designated in Section 1 of this form.

I hereby authorize the use or disclosure of my protected health information (PHI) as described below:
I understand PHI can include the following types of information and authorize its disclosure: medical records; substance abuse care; vision care; reproductive care; mental health; communicable disease; pharmacy; HIV/AIDS; dental records; and psychiatric care.

This protected health information may be disclosed:

The information is being released for the following purpose(s):

Terms and Conditions

By signing below, I hereby authorize the disclosure of my PHI by the agency. I understand that:

- This authorization expires on the following date or event , or upon revocation by me in writing, whichever occurs first.
- I may revoke this authorization at any time. If I revoke this authorization, the revocation is not effective for the sue or for the disclosure of my information that has already occurred.
- Any information used or disclosed pursuant to this authorization could be re-disclosed by the person or entity receiving the information and will likely no longer be protected by federal privacy regulations.
- This authorization is voluntary and that I may refuse to sign it. The provision of treatment, payment or enrollment in a health plan, or eligibility for benefits cannot be conditioned on the signing of this authorization, unless the authorization is necessary for determining eligibility for the program or enrollment in the program.
- In the event my records contain psychotherapy notes, a separate authorization may be required for the release of any psychotherapy notes.
- This authorization permits the use and/or disclosure of information related to HIV testing or the treatment of AIDS or AIDS related conditions, drug or alcohol abuse, psychiatric conditions (excluding psychotherapy notes) unless specifically excluded above.

By signing below, I confirm that I have read and understand the contents of this authorization, and confirm that the contents are consistent with my direction to the entity releasing my information.

Signature of Applicant/Recipient	**Date**

If this form is signed by someone other than the Applicant/Recipient, please describe the authority to act on the individual's behalf (such as Power of Attorney or Legal Guardian). If not already on record with the agency, please provide legal documentation showing this authority.

For more information on the responsibilities of authorized representatives for each benefit program, please refer to the following sections of Ohio Administrative code:
For SNAP see OAC 5101:4-2-05 For Medicaid see OAC 5160: 1-2-01
For TANF see OAC 5101:1-2-01

This institution is an equal opportunity provider. Visit https://www.fns.usda.gov/cr/fns-nondiscrimination-statement. Cuyahoga Job and Family Services provides access to an interpreter at no charge to customers who are limited – English proficient and individuals with impaired vision and/or hearing.

Instructions for Completing the Cuyahoga Job and Family Services Designation of Authorized Representative Form

An authorized representative (AR) is a person or organization who can act on behalf of an individual to help apply for and/or keep Medicaid, SNAP and/or TANF/OWF coverage. Naming an AR is optional and can be time limited.

Individuals may choose to have more than one AR. The AR designation must be in writing. To designate an Authorized Representative and you reside in Cuyahoga County, you may complete the Cuyahoga Job and Family Services Designation of Authorized Representative Form to designate a representative for SNAP, Medicaid and TANF/OWF benefits. Individuals may choose to designate more than one AR, however a separate form is needed for each AR when more than one AR is designated. For more information see:
For SNAP see OAC 5101:4-2-05
For TANF see OAC 5101:1-2-01
For Medicaid see OAC 5160: 1-2-01

Section 1: Designation of Authorized Representative	
Name of Applicant/Recipient	The name of the individual who is choosing to designate an authorized representative.
Street Address City, State, Zip	The residential address of the applicant/recipient or the physical location of the applicant/recipient at the time of completing this form (a nursing home, for example.
Medicaid billing number or Social Security Number (SSN)	The 12-digit Medicaid identification number or Social Security Number of the applicant/recipient.
I hereby authorize the following person or entity to act as my representative. This authority lasts until _____ (*specify a date or event*), or until it is revoked by me in writing.	You may choose how long the individual, entity, or organization can be designated as your authorized representative. Enter a specific date or event in this field to terminate the authorized representative designation at a certain point in time. If no date is specified, the designation of the authorized representative named on this form will last until it is revoked in writing.
Name of Representative	Complete this field if the authorized representative is an individual or a specific individual within an entity or organization. If a specific individual within an entity or organization is identified, but the entity or organization is not listed under “Company”, information under this authorization will only be shared with that specific individual. This field may be left blank if the authorized representative is an entity or organization and no specific individual form the entity or organization is named. In such case, only the “company” field should be completed.
Title	Title of the authorized representative, if applicable. This field may be left blank if the authorized representative is an entity or organization and no specific individual is named. In such case, only the “company” field should be completed.
Company	Complete this field only if the authorized representative is an entity or organization as a whole. If a company is identified in this field, a specific individual may also be identified by completing the “Name of Representative” and “Title” fields above. If only a specific individual is identified, but not the company, the information under this authorization will only be shared

	with that individual within the entity or organization. Leave this field blank if the authorized representative is an individual not affiliated with an entity or organization (such as a family member).
Home Phone	The primary telephone number where the authorized representative may be reached.
Work Phone	The work or secondary telephone number where the authorized representative may be reached (if applicable).
Email Address	Email Address where the authorized representative may be reached (if applicable).
Mailing Address City, State, Zip	The mailing address of the authorized representative. While this authorization is in effect, all notices sent by Cuyahoga Job and Family Services or the Ohio Department of Medicaid (ODM) will also be sent to the authorized representative.
I authorize my representative to do the following on my behalf	Select “act on my behalf on all matters with the agency…” to grant broad permission to the AR OR Choose specific actions you would like your authorized representative to help with (check all boxes that apply).
I authorize my representative to act on my behalf in all business related to the following assistance programs	Select “All Programs” to grant permission to act on your behalf as it relates to SNAP, OWF/TANF and Medicaid benefits. OR Choose only the programs you are granting permission to act on your behalf.
OPTIONAL: SNAP EBT Card Authorization	If you have granted permission to the AR to act on your behalf for “All Programs” or “SNAP” you may choose to grant additional permission to the AR to obtain an SNAP EBT Card on your behalf and use the SNAP EBT card on your behalf. If you do not want the AR to be issued an EBT card on behalf of your assistance group, do not check these boxes.
Signatures	Must be signed by the applicant/recipient named in this document and the authorized representative to be designated. Digital signatures can be accepted so long as digital signature includes the date and time the digital signature was provided.
Signature of Person Granting Authority	Signature of the applicant/recipient or parent/guardian if the individual is a minor. If the person granting the authority is also the applicant/recipient’s guardian or power of attorney, documentation of this designation should be submitted in addition to the completed form.
Date	Enter the date in which the person granting the authority signed the document.
Signature of Authorized Representative	If the authorized representative is an entity or organization, a representative from such entity or organization should sign their name in this field.
Title	Complete this field if the authorized representative is a specific individual within an entity or organization, or if the authorized representative has another title such as power of attorney or guardian.
Date	Enter the date in which the authorized representative signed the document.

The following section must be completed if the authorization in Section 1 is intended to allow the use or disclosure of protected health information (PHI). If you do not intend to allow the use or disclosure of protected health information, you do not need to complete this section.

Section 2: Authorization for the Use and Disclosure of Protected Health Information	
Name of Applicant/Recipient	The name of the individual from Section 1 who chose to designate an authorized representative.
Case Number/Medicaid ID	Existing case number or Medicaid ID of the applicant/recipient (if applicable). If you have ever been issued a Medicaid ID, enter it here.
Date of Birth	Date of birth of the applicant/recipient
I hereby authorize the use or disclosure of my protected health information (PHI) as described below.	By signing this document, you acknowledge that you understand the following types of information are considered PHI: • Medical records • Substance abuse care • Vision care • Reproductive care • Mental health care • Communicable disease • Pharmacy • HIV/AIDS • Dental records • Psychiatric care
This PHI may be disclosed:	This field must be completed to indicate what PHI from the list above that you would like to share. If all PHI from the list above can be shared, sate “all”. If some, but not all types of PHI from the list can be shared, indicate the type(s) of PHI that may be shared.
The information is being released for the following purpose(s)	You may choose to complete this field to state the reason for sharing this information.
Terms and conditions	By signing this form, you acknowledge that you understand these terms and conditions.
Signature of Applicant/Recipient	The individual who is choosing to designate an authorized representative must sign this field. Digital signatures can be accepted so long as digital signature includes the date and time the digital signature was provided.
Date	Enter the date on which the applicant/recipient signed the form.