



ARIZONA DEPARTMENT OF ECONOMIC SECURITY (DES)  
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

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|-----------|-------|--------------------|-----------------|
| CUSTOMER: | DATE: | HEAPLUS PERSON ID: | APPLICATION ID: |
|-----------|-------|--------------------|-----------------|

### Authorized Representative

**Instructions:** Fill out this form to add a person or organization as your authorized representative for your application. Signatures may be required on the next page.

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| Representative's Name:   |  |           |
| Is the representative acting on behalf of an organization? <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |           |
| Organization's Name:   |  |           |
| Is the representative your legal guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |           |
| Representative's Date of Birth (optional):   |  |           |
| Representative's Mailing Address:  |  |           |
| City:  | State:   | ZIP Code: |
| Representative's Phone Number:   | This number is:<br><input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Message<br><input type="checkbox"/> Other: |           |
| Representative's Other Phone Number:   | This number is:<br><input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work <input type="checkbox"/> Message<br><input type="checkbox"/> Other: |           |
| What is the representative's preferred SPOKEN language?  | <input type="checkbox"/> English <input type="checkbox"/> Spanish<br><input type="checkbox"/> Other:   |           |
| What is the representative's preferred WRITTEN language?   | <input type="checkbox"/> English <input type="checkbox"/> Spanish<br><input type="checkbox"/> Other:   |           |
| My representative would like to get an alert that a letter is ready for viewing in HEAplus by:<br><b>(E-mail and text alerts are not available for ALTCS applications)</b> |  |           |
| E-mail: <input type="checkbox"/> Yes <input type="checkbox"/> No<br>E-mail address:  |  |           |
| Text: <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Number to text (standard text rates apply):  |  |           |
| If 'Yes' is not marked for E-mail or Text, all information for this application will be sent via U.S. Mail to the mailing address provided.                                |  |           |

(Continued on next page)

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| <p>By signing below, I, the customer, give permission for the person listed above as my representative to act on my behalf in the process of qualifying me for AHCCCS Medical Assistance, help with Medicare costs, Nutrition Assistance, Cash Assistance, and/or Tuberculosis Control. I, therefore:</p> <ul style="list-style-type: none"> <li>• Give permission for my representative to complete and sign my application.</li> <li>• Give permission for my representative to provide any documents requested, including personal information.</li> <li>• Give permission to my representative to sign on my behalf to permit other people, businesses, or agencies to give personal information about me to DES and/or AHCCCS, including protected health information needed to determine if I am disabled.</li> <li>• Agree to give information about my personal circumstances to my representative.</li> <li>• Agree to allow my representative to assign all my rights to medical reimbursement claims to AHCCCS on my behalf.</li> </ul> | <p>By signing below, I, the representative, agree to act on the customer's behalf. I also agree to:</p> <ul style="list-style-type: none"> <li>• Maintain the confidentiality of any information regarding the applicant or beneficiary provided by the agency.</li> <li>• Provide only truthful and complete information under penalty of perjury.</li> <li>• Fill in and sign needed forms.</li> <li>• Obtain and give to DES and/or AHCCCS all information needed to determine if the customer can qualify for help with healthcare costs, help with Medicare costs, Nutrition Assistance, Cash Assistance, and/or Tuberculosis Control, 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).</li> <li>• Tell DES and/or AHCCCS right away if the customer: <ul style="list-style-type: none"> <li>○ Has an increase or decrease in income;</li> <li>○ Has an increase or decrease in assets;</li> <li>○ Changes ownership of assets, including opening or closing financial accounts;</li> <li>○ Has a change in address; or</li> <li>○ Has a change in health insurance or the amount of premiums paid.</li> </ul> </li> </ul> |
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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 is withdrawn or denied, or when my eligibility ends. However, this authorization will continue during any time while I am contesting my eligibility in an administrative hearing or court proceeding.

|   |   |
|---|---|
| PRINTED NAME OF CUSTOMER                                  | PRINTED NAME OF REPRESENTATIVE                              |
| SIGNATURE OF CUSTOMER                      DATE           | SIGNATURE OF REPRESENTATIVE                      DATE       |
| PRINTED NAME OF WITNESS (ONLY NEED IF SIGNED WITH A MARK) | PRINTED NAME OF REPRESENTING ORGANIZATION (When applicable) |

The customer's signature is not needed when authority has already been accepted by AHCCCS with:

- a court document or POA for the person or organization to act on behalf of the customer; or
- a prior Authorized Representative (DE-112) form designating the person's organization as representative.