Department of Health & Human Services
DHHS
NEBRASKA

Division of Medicaid and Long-Term Care

Designation of Authorized Representative

Client Name: _____ Client Date of Birth: _____ Client Social Security Number: _____

I hereby designate _____ ☐ Individual ☐ Organization, to act responsibly on my behalf in assisting with my application and renewal of eligibility and other ongoing communications with Nebraska Department of Health and Human Services; Division of Medicaid and Long-Term Care.

Authorized Representative (Name, Address, City, State, Zip, phone, email): _____

_____

_____

Scope of this authorization:

☐ Sign an application on the applicant's behalf

☐ Complete and submit a renewal form

☐ Receive copies of the applicant or beneficiary's notices and other communications from the agency

☐ Act on behalf of the applicant or beneficiary in all other matters with the agency

I understand that this designation is valid until I modify the authorization or notify the agency in writing that the Authorized Representative is no longer authorized to act on my behalf. By signing this designation, I acknowledge that the information to be released pursuant to this designation may include material that is protected by federal or state law and may relate to Drug/Alcohol treatment, mental health, and HIV information. I understand that the Nebraska Department of Health and Human Services cannot control what the Authorized Representative does with the released information and that such information might be re-disclosed to a third party. Any released information might no longer be protected by federal or state law. I specifically authorize the Nebraska Department of Health and Human Services to discuss information released pursuant to this designation with the Authorized Representative. Failure to sign this form will not affect treatment, payment, enrollment in a health plan, or eligibility for benefits except in limited circumstances. I understand the advantages and disadvantages and freely and voluntarily give permission to release specific information about me.

Client Signature: _____ Date: _____

Personal Representative: ☐ Parent ☐ Guardian ☐ Power of Attorney Date: _____

Authorized Representative Declarations

As an Authorized Representative I understand (Initial Below):

_____ I am responsible for fulfilling all responsibilities encompassed within the scope of this authorized representation.

_____ I agree to maintain the confidentiality of any information regarding the applicant or beneficiary provided by the agency.

_____ I will adhere to the regulations in Title 42, subpart F, part 431 of the Code of Federal Regulations (CFR) and 45 CFR 155.260(f).

_____ I will adhere to the regulations in Title 42 CFR 447.10, relating to the prohibition against reassignment of provider claims. Please note, this only applies to facilities or organizations acting on a facility's behalf.

_____ I will adhere to all other relevant state and federal laws concerning conflicts of interest and confidentiality of information.

Authorized Representative Signature: _____ Date: _____

If signing on behalf of an organization or entity, the signatory above must be authorized to bind the organization or entity to the terms of this authorization.

NOTICE TO RECIPIENT

This information has been disclosed to you from records whose confidentiality is protected by state and federal laws (to include Federal Regulations, 42 CFR Part 2 of 1983) which prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.