Ohio Department of Medicaid

DESIGNATION OF AUTHORIZED REPRESENTATIVE FOR HOME CARE ATTENDANT SERVICES

Medicaid Billing Number				
Individual First Name	MI	Last Name	County of Residence	
Mailing Address		City	State	Zip Code

I hereby authorize the following individual to represent me regarding *Home Care Attendant Services:*

First Name	MI	Last Name		
Title	Home or Cell Phone		Work Phone	
Mailing Address		City	State	Zip Code

This authorization lasts until *(mm/dd/yyyy)*

I authorize this individual to do the following on my behalf:

☐ Take any action that may be needed to ensure that I receive or continue to receive Home Care Attendant Services.

- OR -

☐ Only perform the specific actions described below.

1.	5.
2.	6.
3.	7.
4.	8.

SIGNATURES

This form has no effect unless signed by the individual granting authority and by the person appointed to be the authorized representative.

Printed Name of Individual Granting Authority	Signature of Individual Granting Authority	Date
Printed Name of Authorized Representative	Signature of Authorized Representative	Date

NOTE: A separately executed HIPAA Authorization is required if the authorized representative requires access to any information in the individual's Medicaid case.