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DIRECTOR OF WELFARE
JEFFREY M. MASCOLL

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MA-84 (Rev. 3/16)

NEW JERSEY MEDICAID PROGRAM DESIGNATION OF AUTHORIZED REPRESENTATIVE

_____ (Name of Applicant) hereby authorizes the following person or company to be my Authorized Representative in my application for Medicaid filed with the County Welfare Agency (CWA) or New Jersey Division of Medical Assistance and Health Services (DMAHS) Office of Institutional Services (ISS) and in all reviews of my eligibility. I authorize my representative to take any action which may be necessary to establish my eligibility for Medicaid.

Name of Representative: _____

Company: _____

Address : _____

City: _____ State: _____ Zip: _____

Phone Number: _____

_____ My decision to appoint an Authorized Representative is voluntary and made freely. I understand that signing this document does not relieve me of my responsibility to participate in the Medicaid eligibility process, including providing information and documents.

_____ I understand that a s a result of this authorization, the DMAHS and applicable CWA may disclose and release information to the Authorized Representative including my Social Security number, financial statements, medical information and reasons for denial.

_____ I have been fully informed in writing by the Authorized Representative of actual or potential conflicts of interest that may exist between the above named entity and me. I hereby waive any conflict of interest. If there is no conflict of interest, the Authorized Representative has also put that in writing.

_____ I understand that the information shared with the Authorized Representative may affect my liability to a third party, including the Authorized Representative and may be disclosed to others. I hereby hold DMAHS and the CWA/ISS harmless for any claim or action resulting from the use or disclosure of information by my Authorized Representative.

_____ I understand that I may revoke this authorization at any time notifying the Authorized Representative and the CWA/ISS in writing.

_____ I understand that while this authorization is in effect, all notices /correspondence sent by DMAHS and the applicable CWA/ISS will only be sent to the Authorized Representative.

☐ I understand that neither the State of New Jersey nor the County Welfare Agency charge a fee to file a Medicaid application.

This form has no effect unless witnessed and signed by the person granting authority and by the Authorized Representative or an agent of the company appointed to be the Authorized Representative.

Signature of Medicaid Applicant or Person Granting Authority: _____

Date:_____

_____
Relationship (Self, Guardian etc.)

Witness _____ Date _____

Print Name _____

_____ _____

Signature of Authorized Representative Title (if employee of authorized company)

_____
Print Name

Date _____

Witness _____ Date _____

Print Name _____