(Sample) AC Representative Certification Letter

MM/DD/YYYY **Application Center ID No.: ## - ## - ####**

MS. JANE SMITH
TRI-PARISH COUNCIL ON AGING
123 SUNSHINE STREET
MARKSVILLE, LA 71329

We are pleased that TRI-PARISH COUNCIL ON AGING is a participant in Louisiana's Medicaid Project. Your designee listed below has successfully completed the Medicaid Application Center Representative training and required testing necessary to become certified to take Medicaid applications.

Upon receipt of this letter, the individual named below is qualified to begin assisting applicants with Medicaid applications. In the event there is a change in your certified staff, you must notify DHH within **ten (10)** working days.

CERTIFIED INDIVIDUAL

NAME	**User Name**
MARY JONES	@

IMPORTANT!! Your USER NAME is the E-mail address (shown above) you provided on your Request for Representative Training Form. Your password will be issued in a separate letter; your password is case sensitive.

You have been given the contact information and instructions for sending your completed applications to Medicaid. For application assistance, contact the Medicaid Customer Service Unit at 1-877-252-2447.

If you have AC program related questions or need additional information, you may contact me or call [Name] at (225) 342-xxxx.

Sincerely,

Name,
Assistant Section Chief