LOUISIANA DEPARTMENT OF HEALTH

Appendix M

EPSDT Beneficiary's Consent for Authorized Representation

I understand that all information gathered, on my behalf and/or for those persons for whom I am responsible, is personal and confidential. I understand that the function of the Authorized Representative is to represent me in the Comprehensive Plan of Care (CPOC) process and to sign CPOC documents on my behalf. I also understand that my authorized representative has the power to make decisions for me concerning all aspects of various Medicaid services administered by the Louisiana Department of Health (LDH). I understand this may require the Department to disclose information to the representative named below that may otherwise be confidential. I hereby waive any rights I may have to prevent disclosure by the Department to the authorized representative named below.

I understand that this authorization is limited solely to the individual named below and is valid until revoked by me. I further understand that I may cancel my appointment of the individual(s) named below as my Authorized Representative at any time upon written notice to the Department.

I understand that while some of the information gathered may have no impact on Medicaid services received, it may affect my liability to a third party should this information be disclosed to the third party by my Authorized Representative. I hereby hold the Louisiana Department of Health (LDH) harmless for any claim resulting from disclosure of information to a third party by my Authorized Representative.

I understand that if this authorization is not signed in the presence of agency staff or a program representative, a confirmation of authenticity may be conducted by agency staff.

_____	_____	_____
Beneficiary's Name	SSN#	ID#

Authorized Representative Name: _____

Address: _____

Telephone Number (Home): _____ (Work): _____

Authorized Representative Signature: _____ Date: _____

Beneficiary's Signature: _____ Date: _____

NOTE: Beneficiary must be a competent major and must personally sign or make their mark on this document to have an authorized representative. If the authorized representative is being contacted and followed up with instead of the beneficiary, there must be documentation to support the beneficiary's request to have the authorized representative contacted or documentation of the beneficiary's inability to self-direct their care. If the beneficiary is not a competent major, do not complete this form; the SC must retain proof of legal guardianship / status (i.e. court order).

Witness' Signature: _____ Date: _____

Support Coordinator's Signature: _____ Date: _____