

Authorized Representative

An Authorized Representative is someone you designate to represent you when you apply for or receive benefits with the Department of Social and Health Services (DSHS) or Health Care Authority (HCA). This individual or organization is authorized to act on your behalf for eligibility purposes. Having an authorized representative is optional; DSHS or HCA cannot withhold benefits if you do not sign this form.

| Client Information | | | |
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| NAME | | ACES CLIENT ID NUMBER | |
| Authorized Representative Information | | | |
| NAME | ORGANIZATION AND DEPARTMENT (IF APPLICABLE) | PHONE NUMBER (AREA CODE) | |
| MAILING ADDRESS | CITY | STATE | ZIP CODE |
| Program and Duration Information | | | |
| <p>Which program(s) do you want your authorized representative to act on in your behalf? Check all that apply. <input type="checkbox"/> Cash Benefits <input type="checkbox"/> Basic Food Benefits <input type="checkbox"/> Health Care Coverage <input type="checkbox"/> Long-term Care Coverage</p> <p>How long do you want your authorized representative to act on your behalf? <input type="checkbox"/> 90 days <input type="checkbox"/> End of certification period (usually one year)</p> <p>You may withdraw or revoke your request for an authorized representative at any time, verbally or in writing, without any impact on benefits.</p> | | | |
| Correspondence Information | | | |
| <p>Please check the level of information or benefits you want your authorized representative to receive.</p> <p><u>For Cash, Basic Food, Health Care Coverage or Long-Term Care</u> <u>(check only one of the four boxes below)</u></p> <p><input type="checkbox"/> Discuss my eligibility for benefits with a DSHS/HCA representative and not receive letters.....</p> <p><input type="checkbox"/> Receive DSHS/HCA letters and discuss my eligibility for benefits.....</p> <p><input type="checkbox"/> Receive DSHS/HCA letters, renewal forms and discuss my eligibility for benefits.....</p> <p><input type="checkbox"/> Receive DSHS/HCA letters, renewal forms, payments, ProviderOne cards and discuss my eligibility for benefits.....</p> <p><u>For Health Care Coverage Only (check either box below if applicable)</u></p> <p><input type="checkbox"/> Hospital representative – receive letters and discuss my eligibility for benefits.....</p> <p><input type="checkbox"/> Sponsor paying premiums. Sponsors name and address sent to Office of Financial Recovery</p> | | | <p>FOR DEPARTMENT USE ONLY</p> <p>Rep Type</p> <p>NC</p> <p>NO</p> <p>AD</p> <p>NA</p> <p>HO</p> <p>SB</p> |
| Client Authorization | | | |
| AUTHORIZED BY (CLIENT SIGNATURE) | DATE SIGNED | PRINT NAME | PHONE NUMBER (AREA CODE) |

NOTE: HIPAA restrictions prevent us from discussing the client's individual health information with the authorized representative unless the representative has power of attorney for the client or the client has signed a [DSHS 14-012, Consent form](#). This includes disclosure of mental health information, HIV/AIDS and STD test results, or treatment and chemical dependency services.

**FOR DEPARTMENT USE ONLY
INSTRUCTIONS**

Rep Type – ACES does not limit the Rep Type selections to the codes listed above. If a program requires a Rep Type not listed above or if one of the above codes is selected but is not appropriate for the situation (such as for a group home, protective payee, etc.) enter the appropriate program specific Rep Type on the AREP screen.

DSHS 14-532 (REV. 11/2014)

Barcode label



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