MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

APPOINTMENT OF AUTHORIZED REPRESENTATIVE

You do not need to sign this form to apply for or receive MO HealthNet benefits. You may contact the Family Support Division to apply for benefits, complete your annual review, or conduct other business on your own; or you may appoint an authorized representative to represent you, as provided by 42 CFR 435.908. To appoint an authorized representative, you must complete this form and the person you appoint to be your authorized representative must acknowledge and accept the appointment. **Notwithstanding the availability of the authorized representative, the Family Support Division may communicate directly with you as the division may determine appropriate.**

I, (PRINT NAME)_____

TELEPHONE NUMBER_____

ADDRESS_____

DCN OR SSN_____

HEREBY APPOINT

NAME (PRINT NAME)_____

TELEPHONE NUMBER_____

ADDRESS_____

E-MAIL ADDRESS_____

TO ACT AS MY AUTHORIZED REPRESENTATIVE.

THIS INDIVIDUAL/ORGANIZATION IS DESIGNATED AS MY AUTHORIZED REPRESENTATIVE TO RECEIVE CORRESPONDENCE FROM THE FAMILY SUPPORT DIVISION.

☐ YES ☐ NO

THE APPOINTED INDIVIDUAL/ORGANIZATION WILL ACT WITH A RESPONSIBILITY AND OBLIGATION TO ME FOR THE FOLLOWING PURPOSE:

☐ APPLICATION

☐ ANNUAL REVIEW

☐ AGENCY ACTION

The person/organization I have appointed has knowledge of my circumstances necessary to complete an application, annual review or act on my behalf and shall not willfully make a false statement, misrepresentation, conceal information, or fail to report any fact or event required to be reported by any law, regulation or rule of this State or the United States.

I understand that I am responsible for the information provided by my authorized representative, including any information that may be incorrect.

APPLICANT/PARTICIPANT SIGNATURE

DATE

ACKNOWLEDGEMENT AND ACCEPTANCE OF APPOINTMENT OF AUTHORIZED REPRESENTATIVE

I, (PRINT NAME)_____

TELEPHONE _____

ADDRESS_____

am age 18 or older (not applicable to organization) and have knowledge of the applicant/participant's circumstances necessary to complete an application, annual review or agency action on their behalf. I (or this organization) shall not willfully make a false statement, misrepresentation, conceal information, or fail to report

any fact or event required to be reported by any law, regulation or rule of this State or the United States.

I (or this organization) hereby accept this appointment of authorized representative for the duration and purpose stated above.

AUTHORIZED REPRESENTATIVE SIGNATURE

DATE

IM6-AR INSTRUCTIONS
IM AUTHORIZED REPRESENTATIVE APPOINTMENT
(MO HealthNet Programs)

Purpose: To provide a signed statement for an applicant/participant designating an individual (18 years or older) or organization to be their authorized representative to apply for MO HealthNet programs on the behalf of an applicant/participant, to assist the participant with the annual review process or a specific agency action.

This form is required to be completed if the MO HealthNet application is made by an authorized representative or if the applicant/participant wishes to appoint an authorized representative to assist them with an annual review or agency action.

This form does not authorize an authorized representative access to protected health information that may be contained in a record with the Family Support Division. If applicant/participant wishes to have protected health information released to their authorized representative, they

must request this release and disclosure of information by completing the Department of Social Services HIPAA compliant release form 650-2616 (HIPPA) Authorization of Disclosure of Consumer Medical/Health Information.

An applicant or participant cannot appoint an authorized representative if the applicant or participant already has a guardian and/or conservator recognized under Missouri law or an attorney-in-fact appointed by a valid Power of Attorney recognized under Missouri law. The attorney-in-fact, guardian or conservator may authorize an individual/organization to act as an authorized representative.

Number of Copies and Distribution: This form is available in hard copy or PDF. The original is completed by the applicant/participant and is filed in the record as a permanent part of the record. A copy of the original must be given to the applicant/participant. The individual/ organization appointed as authorized representative may request or keep a copy for their records.

Instructions for Completion of Authorized Representative appointment: The IM Authorized Representative section of the form is completed by the applicant/participant. It may be completed up to 30 days prior to the application date, annual review date or agency action date.

The **applicant/participant must** complete the form as follows:

- print their name, telephone number, address, and DCN or SSN in the first four blanks.
- print the name, telephone number, and address of the individual/organization they are appointing to be their representative in the next three blanks.
- complete the Purpose of Authorized Representative Appointment

section; indicate the purpose for which they are appointing an authorized representative by checking Application, Annual Review, or Agency Action.

- sign and date; the applicant/participant must sign to appoint the named Authorized Representative. The individual/organization the applicant/participant appoints as an authorized representative must sign and date the form appointing the individual/organization named as their authorized representative.

The **individual/organization appointed as authorized representative must** complete the form as follows:

- print the name, telephone number and address in the first three blanks.
- sign and date; the individual/organization appointed as authorized representative must sign and date the acknowledgment and acceptance of authorized representative appointment.

NOTE: If an organization is appointed as the authorized representative an additional form, AUTHORIZED REPRESENTATIVE ORGANIZATION DESIGNATED CONTACT (IM-6ARO), must be filled out. See the IM-6ARO for instructions.

Duration of Appointment: The authorization will remain in effect until:
Thirty (30) days after the authorization is signed, if no application is received; or
The Division receives written notice that the authorization has been revoked by the applicant or participant; or
The Division receives notice that the applicant or participant is deceased.