Health Care Responsibility Act (HCRA)
Designated Authorized Representative Form

I, _____, hereby appoint _____ as
(Please print applicant's full name) (Please print representative's full name)
my designated representative in connection with my Health Care Responsibility Act (HCRA) application.

On my behalf, I authorize this individual to submit any information requested, to communicate with, to request and receive information or notices, and to appear for appointments as it relates to my HCRA application with my county of residence and/or the Agency for Health Care Administration (Agency). I further authorize release of my medical and financial records to my designated authorized representative, my county of residence, and/or the Agency as deemed necessary in connection with my HCRA application.

The applicant, recipient, and/or designated representative are responsible for the following:

- Completing and signing the HCRA application,
- Assisting in eligibility determinations by providing accurate sources of information and verification in regards to the applicant's residency, income, assets, and other eligibility requirements (should it be determined that fraud was committed or incorrect information was provided intentionally which resulted in an inappropriate eligibility determination, the applicant will be responsible for repaying any amounts paid on their behalf),
- Keeping appointments (failure to do so, without good cause, may result in the application being denied), and
- If applicable, spend-down provision applicants must pay the amount of their share of cost to the hospital.

I understand that I reserve the right to discontinue the services of my designated representative at any time by providing my county of residence and/or the Agency with a written statement to this effect.

_____ _____
Applicant's Signature Date

_____ _____
Designated Representative's Signature Date

_____ (_____)_____
Designated Representative's Mailing Address Phone #