IDAHO DEPARTMENT OF HEALTH & WELFARE

Authorized Representative Form

HW2019 | Rev. 02/2022

You may give a trusted person, such as a friend, partner, third party caseworker or an organization permission to talk about this application with us, see your information, and act for you on all matters related to this application, including getting information about your application and signing your application and/or renewal information on your behalf. This person is called an "authorized representative."

If you ever need to change your authorized representative or revoke the access to your information, contact the Department to complete a new Authorized Representative Form or to update your information about who can access your account.

If you are a legally appointed representative for someone on this application, you must submit proof, such as Power of Attorney, with the application.

Tell us about yourself

1. Full name	First	Middle	Last
2. Social Security number			
3. Date of birth			

Tell us who you want to name as your authorized representative

1. Full name	First	Middle	Last		
2. Relationship to applicant					
3. Mailing address	Street	City	State	Zip	County
4. Phone			Phone type	☐ Home	☐ Work ☐ Cell
5. Email					

Complete this section for an organization to be your authorized representative

1. Organization name					
2. Organization ID *(if applicable)*					
3. Mailing address	Street	City	State	Zip	County
4. Phone					
5. Email *(if applicable)*					

Signature

As an authorized representative, I understand that I agree to maintain the confidentiality of any information regarding the applicant or beneficiary provided by the Department of Health and Welfare. For Medicaid, I understand that any person who knowingly and willfully uses or discloses information in violation of section 1411(g) of the Affordable Care Act will be subject to a CMP of not more than $25,000 as adjusted annually under 45 CFR part 102 per person or entity, per use or disclosure, consistent with the bases and process for imposing civil penalties specified at §155.285, in addition to other penalties that may be prescribed by law.

Printed name of authorized representative	Signature of authorized representative	Date
(In the case of an Organization, please provide a name of someone attesting to the terms and conditions of this form)		
Printed name of applicant	Signature of applicant	Date