Ashtabula County Job & Family Services

Patrick J. Arcaro, Executive Director

ACTS Toll Free	OhioMeansJobs	Social Services / Child Care	Financial / Medical Asst. Services	Fraud Hot-Line Enforcement	Nursing Home Services	Child Support Enforcement
Ph: 1-800-445-4140	**Ph: 440-994-1234**	**Ph: 440-998-1110**	**Ph: 440-998-1110**	**Ph: 440-998-1110**	**Ph: 440-998-1110**	**Ph: 440-994-1212**
Fax: 440-994-2041	Fax: 440-992-7826	Fax: 440-998-1538	Fax: 440-998-1538	Fax: 440-998-1538	Fax: 440-998-1538	Fax: 440-998-1538

DESIGNATION OF AUTHORIZED REPRESENTATIVE

Name of Applicant/Recipient			Case No.
Full Street Address	City	Zip	County **Ashtabula**

I hereby authorize the following person or company to act as my representative:

Name of Representative			Home Phone
Name of Company or Organization			Work Phone
Email Address			
Mailing Address	City	State	Zip

I authorize this person or company to represent me regarding:

☐ Food Assistance ☐ Cash Assistance ☐ Medicaid ☐ Child Care

This authority lasts until:

- My application has been approved
- I rescind this authority
- Other (please specify a date or action) _____

I authorize my authorized representative to do the following on my behalf:

- Act on my behalf in all matters with Ashtabula County Job & Family Services, Ohio Department of Medicaid, and Department of Medicaid's contracted designees

OR only the specific actions selected below:

- Assist with my application/renewal for benefits
- Represent me at a state hearing
- Receive and respond to copies of all correspondence
- Provide verifications on my behalf
- Discuss and receive information regarding my financial and medical information including protected health information (PHI)*
- Other (please specify) _____

*Note You must complete page 2 of this form if this authorization is intended to allow the use or disclosure of PHI

While this authorization is in effect, all notices sent by Ashtabula County Job & Family Services, Department of Medicaid, or the Ohio Department of Job & Family Services will also be sent to your authorized representative

Signatures. This form has no effect unless signed by both the person granting authority AND by the authorized representative. By signing below, the authorized representative agrees to maintain the confidentiality of any information regarding the applicant/recipient provided by the agency. If the authorized representative is a provider, staff member, or volunteer of an organization, then the authorized representative also agrees to adhere to the regulations cited in 42 C.F.R. 435.923(e)

Signature of Person Granting Authority _____ **Date**_____

Signature of Authorized Representative _____ **Date**_____

2924 Donahoe Dr., Ashtabula, OH 44004
E-mail: ashtabula-verifications@jfs.ohio.gov
Toll Free: 1-800-935-0242
Fax: 440-998-1538

Section 2

Authorization for the Use and Disclosure of Protected Health Information

Name of Applicant/Recipient	Case Number/Medicaid ID		Date of Birth
Address	City	State	Zip Code

Ashtabula County Job & Family Services (ACJFS), the Ohio Department of Medicaid (ODM) and ODM's contracted designees *(including Medicaid managed care plans)* are authorized to disclose my protected health information (PHI) to my authorized representative designated in Section 1 of this form.

I hereby authorize the use or disclosure of my protected health information (PHI) as described below. I understand PHI can include the following types of information, and authorize its disclosure: medical records, substance abuse care, vision care, reproductive care, mental health, communicable disease, pharmacy, HIV/AIDS, dental records, and psychiatric care.

The information is being released for the following purpose(s):

Terms and Conditions

By signing below, I hereby authorize the disclosure of my PHI by the agency. I understand that:

- This authorization expires on the following date or event, or upon revocation by me in writing, whichever occurs first.
- I may revoke this authorization at any time. If I revoke this authorization, the revocation is not effective for the use or for the disclosure of my information that has already occurred.
- Any information used or disclosed pursuant to this authorization could be re-disclosed by the person or entity receiving the information and will likely no longer be protected by federal privacy regulations.
- This authorization is voluntary, and I may refuse to sign it. The provision of treatment, payment, enrollment in a health plan, or eligibility for benefits cannot be conditioned on the signing of this authorization, unless the authorization is necessary for determining eligibility for the program or enrollment in the program.
- In the event my records contain psychotherapy notes, a separate authorization may be required for the release of any psychotherapy notes.
- This authorization permits the use and/or disclosure of information related to HIV testing or the treatment of AIDS or AIDS related conditions, drug or alcohol abuse, psychiatric conditions (excluding psychotherapy notes) unless specifically excluded above.

By signing below, I confirm that I have read and understand the contents of this authorization and confirm that the contents are consistent with my direction to the entity releasing my information.

Signature of Applicant/Recipient	**Date**

If this form is signed by someone other than the Applicant/Recipient, please describe the authority to act on the individual's behalf *(such as Power of Attorney or Legal Guardian)*. If not already on record with the agency, please provide legal documentation showing this authority.