

Appointment of Authorized Representative

Use this form to appoint an individual or organization as your Medi-Cal authorized representative. Your authorized representative may act for you on all duties related to your Medi-Cal eligibility and enrollment. Or, you may also limit duties. You may cancel or change this appointment at any time.

You may give this form to your local county office in person or by mail, phone or electronically.

Part A: Tell us about you:

Applicant or beneficiary name:	Phone number:	Case number (Optional):
X	X	(GMWP Eligibility addrs.)

Mailing address (number, street, city, state, ZIP code):
X

Part B: Tell us about the authorized representative:

Name of authorized representative (individual or organization):	Phone number:
Gary and Mary West PACE (San Diego Cty CBO)	760-280-2230

Mailing address (number, street, city, state, ZIP code):
1706 Descanso Ave.San Marcos, CA 92078

E-mail address:
dsullivan@westpace.org

Part C: Authorized representative duties:

Examples of authorized representative duties

- Complete and sign the application
- Complete and sign redetermination forms
- Give us information we ask for
- Report changes
- Choose a health plan
- Help with fair hearings and appeals

Appointment of Authorized Representative

Tell us below if you want to limit any authorized representative duties:

(Circle "No Limits" or briefly indicate limits): No Limits

Do you want your authorized representative to get a copy of Medi-Cal notices or other mail we send to you?

- ☐ No
- ☐ Yes, all notices and mail
- ☒ Yes, please limit to these types of notices or mail: Notices of Action (NOAs) only

Part D: Read and sign

I. For applicant/beneficiary:

By signing below, I appoint the individual or organization named in Part B as my authorized representative. I agree that:

- The authorized representative may perform duties on my behalf. (See Part C.)
- This authorization starts on the date I sign this form.
- My rights and responsibilities do **not** change because I have an authorized representative.
- I must make sure that I respond to all requests for information
- The authorized representative may cancel this appointment at any time.
- I may contact the county that handles my Medi-Cal case to change or cancel this appointment at any time.

II. For authorized representative:

- You may cancel this appointment at any time by contacting the county that handles the applicant or beneficiary's Medi-Cal case.
- If you do not agree with your rights and responsibilities or do not want to be an authorized representative, contact the county that handles the applicant or beneficiary's Medi-Cal case.
- You agree to keep confidential any information about the applicant or beneficiary that you get from Medi-Cal.

Appointment of Authorized Representative

A. For an individual appointed as an authorized representative:

- By accepting appointment as an authorized representative you agree to:
 - Give the written disclosure to the applicant or beneficiary.
 - Obey all state and federal laws governing authorized representatives. These include, but are not limited to, laws about privacy of information, rules against reassigning provider claims, and conflicts of interest.
- If you are an employee or contractor for a health care provider or facility, you must give the applicant or beneficiary a written disclosure about:
 - Your employment by or contract with the health care provider or facility.
 - Any potential conflicts of interest that may exist due to that employment or contract.

B. For an organization appointed as an authorized representative:

- The only persons who may perform duties authorized on this form are those who represent the organization and have a signed Authorized Representative Standard Agreement (MC 383) on file with the county that handles the applicant or beneficiary's Medi-Cal case.
- The organization must fully disclose in writing to the applicant or beneficiary any conflicts of interest that may result from acting as that person's authorized representative.

Medi-Cal confidentiality notice: The information given on this form is private and confidential pursuant to Welfare and Institutions Code, Section 14100.2. This information shall be disclosed only as this law allows.

By signing below, I agree to and understand my rights and responsibilities as stated above:

Signature of applicant or beneficiary (required):	Date:
X	X

Signature of individual appointed as an authorized representative (optional):	Date:
Gary and Mary West PACE:	