

# The MOM Care Program Authorized Representative Designation

Patient Full Name: \_\_\_\_\_

Date of Birth \_\_\_/\_\_\_/\_\_\_

Medicaid Number: \_\_\_\_\_

**PATIENT IS A MINOR CHILD OR IS PHYSICALLY OR MENTALLY INCAPACITATED:**

The following classifications are in order of priority. Please check the applicable classification:

1.  A court-appointed guardian or a guardian appointed by a person legally authorized to appoint a guardian under the statute.
2.  An agent appointed by the patient in accordance with an Advance Directive, Living Will and/or a Durable Power of Attorney for health care.
3.  Spouse of patient (including common law spouse).
4.  Son or daughter nineteen (19) years or older of the patient.
5.  Parent of the patient.     Mother     Father
6.  Brother or sister aged nineteen (19) or older of the adult patient.
7.  Any one of the patient's surviving adult relatives who are of the next closest degree of kinship to the patient, Specifically, I am the \_\_\_\_\_.

Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_ Time: \_\_\_\_\_

By check one of the above, I hereby certify that I am the legally authorized representative of the named minor child or incapacitated person and to my knowledge, there is no person with a higher classification, I thereby am authorized to receive or to request medical records on behalf of the above named person.

### **PATIENT IS DECEASED:**

1.  Executor/administrator of the estate
2.  Family member or other who was involved in care or payment of care of the decedent prior to death.

Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_ Time: \_\_\_\_\_

By checking on of the above, I hearby certify and I am the executor or administrator of the estate or was involved in the care or payment for care of the decedent prior to death. I thereby am authorized to receive or to request medical records on behalf of the above named person.

Print Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_ City, State, & Zip Code \_\_\_\_\_

Witness' Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_ Time: \_\_\_\_\_

