Designation of Authorized Representative

Section 1 *(Please Print)*

Name of Applicant/Recipient	SSN	County	
Street Address (include Apt #)	**City**	**State**	**Zip**

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

☒ Food Assistance (SNAP) ☒ Cash Assistance ☒ Medicaid

This authority lasts until ***(specify a date or event),*** **or until it is revoked by me in writing.**

Name of Representative	Title	Company
Angela Beyer	JFS Auth Rep	Best Payments
Home Phone	**Work Phone**	**Email Address**
	740-263-7970	angie@bestpayments.net

Mailing Address	City	State	Zip
PO Box 839	Delaware	OH	43015

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

☒ Act on my behalf in all matters with the agency ["agency" includes the County Department of Job & Family Services (CDJFS), the Ohio Department of Medicaid (ODM), and ODM's contracted designees].

OR only the specific action selected below:

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

***Note: You must complete Section 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 the CDJFS and/or ODM 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 (Applicant/Recipient or Parent/Guardian)	Date

Signature of Authorized Representative	Title (if employee of an organization)	Date
Angela Beyer	Best Payments, Rep Payee + JFS AR	