APPOINTMENT OF REPRESENTATIVE

RE: Medicaid #: DO: Worker:

I hereby appoint: ____ (Sponsor's Name)
as my legal representative to act in my stead and on my behalf to apply, reapply and make claim for Medicaid benefits under Title XIX of the Social Security Act from the Alabama Medicaid Agency, hereby ratifying and confirming the acts of my said representative on my behalf. This appointment authorizes my said representative to fully act in my stead in connection with all Medicaid matters involving me, including, but not limited to, making applications, reapplications and claims of all kinds, accepting and giving notice in connection with eligibility determinations and Fair Hearings, requesting information, and presenting and eliciting evidence. This appointment shall remain in full force and effect until I have notified the Alabama Medicaid Agency in writing that this authority has been withdrawn.

Done this the _____ day of ______________________________, 20 _______.

WITNESSES:

________________________________ ______________________________________
(Signature of Medicaid Claimant)

____

If claimant cannot sign his/her name but can make a mark; this is acceptable if witnessed by two adults.
The mark may be labeled. Example: ___X (Her mark)___Jane Doe____.

If claimant cannot sign his/her name or make a mark and there is no one legally designated as guardian, conservator, etc., representative must answer the questions below:

What is your relationship to claimant? ____

Why can't claimant sign? ____

To what extent are you responsible for claimant? ____

If claimant has a legally appointed guardian, conservator or someone with durable power of attorney who will represent him/her for Medicaid purposes, claimant's signature on this form is not required. **Representative should sign the Representative portion of the form only and attach to this form a copy of evidence of legal authority to act on claimant's behalf (Letter of Conservatorship/Guardianship or Durable Power of Attorney).**

ACCEPTANCE OF APPOINTMENT

I hereby accept the foregoing appointment. I certify that I have not been suspended or prohibited from practice before the Alabama Medicaid Agency and am not otherwise disqualified from acting as an appointed representative. I acknowledge that representations and applications made by me on behalf of the claimant are made under an affirmation which subjects me to penalties for perjury and that false statements may subject me to penalties or fraud.
As an Authorized Representative, I agree to the following:

- Maintain the confidentiality of any information regarding the Medicaid client provided by the Alabama Medicaid Agency,
- Comply with state and federal laws and regulations concerning the protection of Medicaid client confidentiality and avoiding conflicts of interest,
- Comply with federal safeguard provisions in regards to Medicaid client information, and,
- Comply with federal prohibitions against the reassignment of claims against the Medicaid client.

My relationship to the above is ____ (Attorney, relative, etc.)

Done this the ________________________ day of ______________________________, 20 _______.

WITNESSES:

____ ____
(Signature of Sponsor/Representative)

____

____
(Address)

____
City, State)

____
(Telephone Number)

Notice to Applicants and Sponsors

Federal and state laws provide both criminal and civil penalties for false statements or material omissions in an application for Medicaid benefits or payments. Also, any application found to contain material misstatements or omissions will be denied.

The following statutes are excerpts from the Code of Alabama pertaining to the Medicaid program:

§ 22-1-11. Making false statement or representation of material fact in claim or application for payments on medical benefits from medicaid agency generally; kickbacks, bribes, etc.; exceptions; multiple offenses.

(a) Any person who, with intent to defraud or deceive, makes, or causes to be made or assists in the preparation of any false statement representation or omission of a material fact in any claim or application for any payment, regardless of amount, from the medicaid agency, knowing the same to be false; or with intent to defraud or deceive, makes, or causes to be made, or assists in the preparation of any false statement, representation or omission of a material fact in any claim or application for medical benefits from the medicaid agency, knowing the same to be false; shall be guilty of a felony and upon conviction thereof shall be fined not more than $10,000.00 or imprisoned for not less than one nor more than five years, or both.

* * *

(e) Any two or more offenses in violation of this section may be charged in the same indictment in separate counts for each offense and such offense shall be tried together, with separate sentences being imposed for each offense of which defendant is found guilty. (Acts 1980, No. 80-539, p. 837, Sections 1-5.)

§ 22-6-8, Revocation of eligibility of recipient upon determination of abuse, fraud, or misuse of benefits; when eligibility may be restored.

(a) Upon determination by a utilization review committee of the designated state medicaid agency that a medicaid recipient has abused, defrauded, or misused the benefits of the program said recipient shall immediately become ineligible for medicaid benefits.

(b) Medicaid recipients whose eligibility has been revoked due to abuse, fraud or other deliberate misuse of the program shall not be deemed eligible for future medicaid services for a period of not less than one year and until full restitution has been made to the designated state medicaid agency.

(c) The provisions of this section shall not be effective if they are found by a court of competent jurisdiction to contravene federal laws or federal regulations applicable to the medicaid program. (Acts 1980, No. 80-127, p. 190.)