AUTHORIZATION TO REPRESENT

I hereby authorize L & S Associates, Inc. (L & S) or its designee(s) to act as my Authorized Representative in all proceedings necessary to establish eligibility for Medicaid, including representing me in all phases of the application process and appeal, serving as my Authorized Hearing Representative, including authorization to request administrative hearing(s) and appeals on my behalf that L & S deems necessary. There is no one in my family who is willing or able to act on my behalf as they do not understand the complexities of the numerous Medicaid programs. I authorize and request that the Governmental Agency determining my eligibility or its successor agency direct all correspondence regarding my application to L & S Associates, Inc. as well as myself.

I understand that this Authorization to Represent is not effective until L & S agrees to serve as my Authorized Representative and that L & S will notify me of its decision by contacting me through my last known telephone number, email address, or by first class mail at my street address. If L & S agrees to serve as my Authorized Representative and as my Authorized Hearing Representative, the effective date shall be the first date L & S acts on my behalf.

Once accepted by L & S, this Authorization to Represent will remain in effect until one party notifies the other party that it is terminated. If I terminate this Authorization to Represent, I will notify L & S in writing of my decision, sent to L & S's last known address by first class mail. If L & S terminates this Authorization to Represent, it will notify me in writing, sent to me at my last known address by first class mail.

I understand that L & S cannot guarantee my eligibility and is not responsible should I be denied Medicaid for any reason.

I understand that one or more of my health care providers have agreed to pay L & S's fees for services that L & S may provide to me. I authorize L & S to share any financial information it obtains about me and/or my family with any health care provider who has agreed to pay L & S's fees.

I understand that this Authorization to Represent authorizes L & S to represent me for purposes of establishing Medicaid coverage only. I have not authorized L & S to serve as my authorized representative for any other purpose, including, but not limited to, serving as my Authorized Representative for any other governmental programs, benefits, or review of my eligibility for ongoing Medicaid. From time to time, L & S may assist me in pursuing other avenues of health care coverage. I understand that L & S is not representing me in those pursuits by providing me such assistance and that L & S cannot be held liable if I am denied health care benefits or coverage under any plan, program, policy or procedures. I further understand that L & S is not a law firm and will not provide me with legal advice. If DCS, a division of L & S, represents me for establishing disability benefits through Social Security, I will be required to execute an additional Authorization to Represent.

____ ____________________

Client Signature (Guardian/Spouse if patient is incapacitated) *Date of Birth*

____ ____________________

Please Print Name / Relationship to Client *Date*

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