STATE OF HAWAII
Department of Human Services

Med-QUEST Division

DESIGNATION OR REVOCATION OF AN AUTHORIZED REPRESENTATIVE

I, _____ ☐ **DESIGNATE or** ☐ **REVOKE**
PRINT Applicant/Beneficiary First Name Middle Initial Last Name

_____ **to act on my behalf in all medical**
PRINT Authorized Representative First Name Middle Initial Last Name or Organization

assistance matters with the Department.

_____
Applicant/Beneficiary Signature Date Mailing Address City State Zip Code

If signed with "x" by the Applicant/Beneficiary:

_____ _____ _____
PRINT Witness First Name Middle Initial Last Name Signature of Witness Date

Note: Witness cannot be your designated Authorized Representative.

This authorization is valid from the DATE OR *EVENT this form is signed by the Applicant/Beneficiary:

Date _____ / _____ / _____ **OR Event:** _____
Month Day Year

As the Authorized Representative, by signing below:

1. I understand that as a condition of serving as an Authorized Representative, I must affirm that I will adhere to the regulations in 42 CFR 431 Subpart F (relating to safeguarding information on applicants and beneficiaries), 42 CFR 435.923 (relating to authorized representatives), 45 CFR 155.260 (relating to confidentiality of information) and 42 CFR 447.10 (relating to the prohibition against reassignment of provider claims as appropriate for the facility or an organization action on the facility's behalf).
2. I agree that I shall be legally bound by the federal and state authorities related to authorized representatives, including but not limited to maintaining the confidentiality of any information provided to me by the Department or its designee in compliance with all state and federal confidentiality laws and conflicts of interest laws.
3. I understand that my role as an authorized representative for the purposes of Medicaid shall terminate when:
   a. Revoked by an applicant/beneficiary with decisional capacity;
   b. Upon appointment or availability of a Guardian or Power of Attorney designated to make health care decisions for the applicant/beneficiary: or
   c. Upon the applicant/beneficiary's death.
4. I also understand that my role as an authorized representative is valid until:
   a. The applicant/beneficiary withdraws the authorization by notifying the Department that I am no longer authorized to act on the applicant's or beneficiary's behalf;
   b. There is a change in the legal document of authority to act on the applicant's or beneficiary's behalf; or
   c. I inform the Department that I am no longer acting as the applicant/beneficiary's authorized representative.

_____
Signature of Authorized Representative (required) Telephone Date

_____
Mailing Address City State Zip Code

*** EVENT-**The Privacy Rule requires that an Authorization contain either an expiration date or an expiration event that relates to the individual or the purpose of the disclosure. For example, an Authorization may expire "one year from the date the Authorization is signed" or "upon termination of enrollment in the health plan."

FOR OFFICIAL USE ONLY	UNIT:		WKR:		CID:		Date:	

FORM PURPOSE

The DHS 1121 "Designation or Revocation of an Authorized Representative" form is used as Hawaii Med-QUEST Division's documentation of an applicant's or beneficiary's signed designation or revocation of the Authorized Representative or Organization to act on their behalf in all Medicaid related matters and on-going communications with the Department.

FORM INSTRUCTIONS

An individual chosen to be an Authorized Representative is required to complete and sign the DHS 1121 as it is evidence that the Authorized Representative has attested to maintain the confidentiality of any information regarding the applicant or beneficiary as required by Medicaid regulations and understands regulations in relation to conflicts of interest.

If the applicant or beneficiary is signing with an "x" as their signature, they acknowledge and accept the information contained in the DHS 1121. A witness of the applicant/beneficiary mark is required to ensure that the applicant/beneficiary made the mark and was not forged. The witness cannot be the designated Authorized Representative.

1. PRINT the Applicant/Beneficiary full name and check appropriate box to designate or revoke authorization of representative.

2. PRINT the Authorized Representative full name.

3. PRINT the Applicant/Beneficiary address.

4. The Applicant/Beneficiary shall sign their name and date.

5. The Applicant/Beneficiary **must** complete the Date or Event that the authorization is valid until. If the Date or Event is left blank the authorization is not valid.

6. The Designate Authorized Representative **must** review, complete their mailing address and telephone number, and sign and date in the area designated to affirm that they understand the regulations relating to being designated as the Applicant/Beneficiary Authorized Representative.

7. Upon completion of this form, return the original and a copy of the document authorizing you to be a representative to your assigned eligibility worker. You may also contact Customer Service at 524-3370 or for your neighbor islands 1-800-316-8005, (TTY/TDD 711) for additional information. You may keep a copy of this form for your records.