

**INSTRUCTIONS (STAFF ONLY)**

**DHS 1121 (Rev. 10/18)**

**DESIGNATION OR REVOCATION OF AN AUTHORIZED REPRESENTATIVE**

**PURPOSE:**

The DHS 1121 "Designation or Revocation of an Authorized Representative" form shall be completed to document 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.

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.

**SPECIFIC INSTRUCTIONS:**

**For 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 of a designated Applicant/Beneficiary Authorized Representative.
7. Upon completion of this form, the Authorized Representative shall return the original and a copy of the document authorizing them as the representative to their assigned eligibility worker. They may also contact Customer Service at 524-3370 or for the neighbor islands 1-800-316-8005, (TTY/TDD 711) for additional information.

**For Med-QUEST Division Eligibility Staff:**

1. The EW shall verify required information is completed on the DHS 1121.  
**Note: 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."**
2. If the form is incomplete, the DHS 1121 shall be returned to the Applicant/Beneficiary for completion.
3. If the form is complete, the EW shall complete the "official use only" portion of the form.
  - a. UNIT-Self Explanatory
  - b. WKR-Worker
  - c. CID-Client ID
  - d. DATE-Date worker reviewed completed form.

**FILING/DISTRIBUTION INSTRUCTIONS:**

1. EB shall document the "designation of authority" or any changes to the individual in appropriate KOLEA case.
2. EB shall scan DHS 1121 form into the appropriate KOLEA case file as appropriate.
3. EB shall send copy of the signed DHS 1121 to the Applicant/Beneficiary.