STATE OF HAWAII
Department of Human Services

Med-QUEST Division
P. O. Box 700190
Kapolei, HI 96709-0190

AGREEMENT TO ACT AS AN AUTHORIZED REPRESENTATIVE

Under the penalty of false swearing, I _____
*Representative for Applicant/Beneficiary-First Middle Initial Last Name

declare that there are facts and circumstances reasonably sufficient to establish my role as an Authorized Representative for _____.
PRINT Applicant/Beneficiary First Name Middle Initial Last Name

Supporting Documentation Type (Required): ☐ Health Care Surrogate Form ☐ POA ☐ Court Order ☐ Other Legal Document_____
Describe Type of Documentation

_____
Effective Date of Supporting Documentation

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 POA 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 Healthcare Surrogate, POA, Court Appointed or Other Authorized Legal Representative Telephone Date

_____
Mailing Address City State Zip Code

The *Representative includes a Health Care Surrogate, Power of Attorney (POA), Court Appointed Representative or Other Authorized Individual who agrees to be an Authorized Representative for an incapacitated person, is required to sign the DHS 1121A as evidence they attest to hold things confidential as required by Medicaid regulations and understand regulations in relation to conflicts of interest.

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

FORM PURPOSE

The DHS 1121A "Agreement to Act as an Authorized Representative" form is used as Hawaii Med-QUEST Division's documentation for a Healthcare Surrogate, Power of Attorney (POA), Court Appointed Representative or Other Authorized Individual who has agreed to act as an Authorized Representative for an incapacitated person.

FORM INSTRUCTIONS

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

NOTE: A Healthcare surrogate is limited to the following interested persons: spouse (except if legally separated or estranged), reciprocal beneficiary, adult child, parent, adult sibling, or adult grandchild of applicant/beneficiary or any adult who has exhibited special care and concern and is familiar with the applicant/beneficiary's personal values.

1. PRINT the name of the individual who is designated to act as the Authorized Representative on the DHS 1121A.

2. PRINT the name of the Applicant/Beneficiary and check the appropriate supporting documentation type (i.e. copy of surrogate form, Power of Attorney, Court Order or Other legal documentation) is attached to the DHS 1121A.

3. If "Other" is checked, describe the type of documentation attached to the form and write in the effective date of the supporting documentation.

4. The Healthcare Surrogate, Power of Attorney (POA), Court Appointed or Other Authorized Individual designated as the Authorized Representative **must** sign/date in the designated area with a contact number and mailing address.

5. Upon completion of this form, return the original and 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.