

Acknowledgement of Responsibilities
Authorized Representative

An authorized representative, or responsible person, is someone who acts for another individual either with the individual's consent or at the order of an appropriate court.

To apply for Medicaid for someone while acting as his or her authorized representative, you are obligated to tell the South Carolina Department of Health and Human Services all that you know about the individual's situation, whether personal, financial, medical, etc. It does not mean that you will be personally responsible for the individual's debts. Any agreements that you make with providers of medical services or other individuals related to the individual for whom you are applying are your responsibility, and the Department has no control or influence in such matters.

Name and Address of Applicant:	Limits of programs for which this person is applying:
	<ul style="list-style-type: none"> ➤ Income: _____ ➤ Resources: _____

1. By agreeing to act as authorized representative for this applicant/beneficiary, you agree to be responsible for reporting any changes in income or resources within 10 days of the change or as soon as you become aware of the change. *Examples of changes that may be reported:*
 - Increase or decrease in monthly income
 - Receipt of a lump sum
 - Receipt of any regular monthly income payments
 - Change of address
 - Receiving or selling property
 - Death of an individual or of a spouse or any relative living in the home

2. By agreeing to act as an authorized representative for this applicant/beneficiary, you agree to be responsible for reporting any requested changes to Medicaid Managed Care Enrollment as soon as you become aware of the change. *Examples of changes that must be reported:*
 - Choices and changes in Medicaid managed care health plans (Managed Care Organizations or Medical Homes Networks) or Fee-For-Service Medicaid
 - Choices and changes in Primary Care Providers (for Medical Homes Networks only)

3. By agreeing to act as an authorized representative for this applicant/beneficiary, you understand that if you deliberately give false information or withhold any information concerning the individual's situation, you are liable for prosecution for fraud and/or perjury. You are not liable for changes of which you are not aware.

If you agree to fulfill the responsibilities of an authorized representative, please sign and date below:	
Authorized Representative:	Date:
Address:	

Medicaid Worker:	Date:
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After you complete this form, you can FAX it or mail it to South Carolina Healthy Connections Choices.

- FAX to: 1-877-552-4672, or
- Mail to: South Carolina Healthy Connections Choices
P.O. Box 8592
Columbia, SC 29202-8592