SB2 HEALTHCARE | **2021**

OH DESIGNATION OF AUTHORIZED REPRESENTATIVE

DATE: 05/03/2022

RESIDENTS NAME:
Regina Wilson

SOCIAL SECURITY #:
280608491

FACILITY NAME
Parkside Villa

FACILITY ADDRESS
7040 Hepburn Road
Middleburg Heights Ohio 44130

To simplify the Medicaid application process, it can be helpful to designate a facility to act in the interests of a resident. This form authorizes facility and person(s) from the facility to handle your entitlement to Medicaid benefits.

I authorize facility, Parkside Villa subject to federal and state confidentiality/conflict of interest regulations, to be my authorized representative. I also authorize any employees or agents of the facility, including attorneys hired by the facility, to represent me when:

- Initiating an application for Medicaid benefits
- Participating in all reviews of my eligibility for Medicaid benefits
- Taking action as necessary to establish my eligibility for Medicaid
- Taking all actions necessary to obtain payment arising from and relating to Medicaid eligibility and Medicaid claims

With this authorization and in addition to the above, I authorize the facility, its employees and agents, to secure all information necessary to assist with applications for Medicaid filed on my behalf, to determine my eligibility for Medicaid benefits, and/or continued eligibility for Medicaid benefits. This information may include any health information protected under HIPAA, or any of my personal financial and any other information needed.

I authorize the facility, its employees, and agents, to share my personal information to secure my entitlement to Medicaid benefits. I am waiving any and all claims of confidentiality over this information with respect to the facility, its employees, and agents.

I understand and agree that all legal proceedings (in both state and federal courts) arising out of my Medicaid eligibility and/or Medicaid benefits may be pursued either in my name or in the name of the facility. I waive any potential or actual conflicts of interest, which may exist from this appointment of authorized representation.

I also agree that any assistance provided does not prevent the facility and/or its attorneys from taking any actions necessary to recover unlawfully converted/transferred assets that may prevent me from qualifying for Medicaid benefits. It also does not prevent the facility or its attorneys from taking action to remedy something that may prevent me from qualifying for Medicaid benefits. Any information obtained by facility, while providing any assistance in regard to this authorization, may be used by the facility in any future action.

I understand that I may cancel this designation of an authorized representative at any time by notifying, in writing, the authorized representative, the applicable county welfare agency, or court in writing. Any facsimile copy or photocopy of this authorization shall be as valid as the original, this designation survives my death or incapacity, and is made separate from any power of attorneys executed by me.

PRINT NAME
X Shannonn Bennett

TITLE
X Medicaid Liaison
(FACILITY DESIGNEE)

SIGNATURE OF AUTHORIZED REP.
X_____

SIGNATURE OF RESIDENT
X_____

SIGNATURE OF POA/GUARDIAN
X_____
(IF APPLICABLE)