Authorized Representative

An Authorized Representative is someone you designate to represent you when you apply for or receive benefits with the Department of Social and Health Services (DSHS) or Health Care Authority (HCA). This individual or organization is authorized to act on your behalf for eligibility purposes. Having an authorized representative is optional; DSHS or HCA cannot withhold benefits if you do not sign this form.

Client Information

NAME	ACES CLIENT ID NUMBER

Authorized Representative Information

NAME	ORGANIZATION AND DEPARTMENT (IF APPLICABLE)	PHONE NUMBER (AREA CODE)
APPLE PAYEE		509-241-8125

MAILING ADDRESS	CITY	STATE	ZIP CODE
PO BOX 9339	SPOKANE	WA	99209

Program and Duration Information

Which program(s) do you want your authorized representative to act on in your behalf? Check all that apply.

☒ Cash Benefits ☒ Basic Food Benefits ☒ Health Care Coverage ☒ Long-term Care Coverage

How long do you want your authorized representative to act on your behalf?

☐ 90 days ☒ End of certification period (usually one year)

You may withdraw or revoke your request for an authorized representative at any time, verbally or in writing, without any impact on benefits.

Correspondence Information

Please check the level of information or benefits you want your authorized representative to receive.

	FOR DEPARTMENT USE ONLY Rep Type
For Cash, Basic Food, Health Care Coverage or Long-Term Care (check only one of the four boxes below)	
☐ Discuss my eligibility for benefits with a DSHS/HCA representative and not receive letters.....	**NC**
☐ Receive DSHS/HCA letters and discuss my eligibility for benefits.....	**NO**
☐ Receive DSHS/HCA letters, renewal forms and discuss my eligibility for benefits.....	**AD**
☒ Receive DSHS/HCA letters, renewal forms, payments, ProviderOne cards and discuss my eligibility for benefits.....	**NA**
For Health Care Coverage Only (check either box below if applicable)	
☐ Hospital representative – receive letters and discuss my eligibility for benefits.....	**HO**
☐ Sponsor paying premiums. Sponsors name and address sent to Office of Financial Recovery.....	**SB**

Client Authorization

AUTHORIZED BY (CLIENT SIGNATURE)	DATE SIGNED	PRINT NAME	PHONE NUMBER (AREA CODE)

NOTE: HIPAA restrictions prevent us from discussing the client's individual health information with the authorized representative unless the representative has power of attorney for the client or the client has signed a DSHS 14-012, Consent form. This includes disclosure of mental health information, HIV/AIDS and STD test results, or treatment and chemical dependency services.

FOR DEPARTMENT USE ONLY
INSTRUCTIONS

Rep Type – ACES does not limit the Rep Type selections to the codes listed above. If a program requires a Rep Type not listed above or if one of the above codes is selected but is not appropriate for the situation (such as for a group home, protective payee, etc.) enter the appropriate program specific Rep Type on the AREP screen.

Barcode label

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