State of California
Health and Human Services Agency

Authorized Representative Standard Agreement for Organizations

This standard agreement must be completed by the person or persons who will act for the organization that the Medi-Cal applicant or beneficiary has appointed as an authorized representative.

The organization must give this signed and completed form to the county that handles the Medi-Cal case of the applicant or beneficiary. It can be given by mail, phone, electronically or in person. This form is required by federal regulation 42 CFR Section 435.923(e) and Welfare and Institutions Code Section 14014.5(k).

Tell us about the organization and the applicant or beneficiary:

Organization name:	Phone number:

Organization mailing address (number, street, city, state, ZIP code):

Applicant or beneficiary name:	Medi-Cal case number (optional):

Applicant or beneficiary mailing address (number, street, city, state, ZIP code):

By signing below, I hereby accept appointment as an authorized representative for the organization named above. I understand and agree that:

- I am acting as an authorized representative for the above-named organization that the applicant or beneficiary appointed as an authorized representative. I am not acting in my individual capacity.
- I have no power to act for the applicant or beneficiary, except as specified by the applicant or beneficiary.
- The applicant or beneficiary may cancel the appointment at any time and appoint another individual or organization to act as their authorized representative.
- This agreement may not be transferred or reassigned to any person not on this form. To allow any other provider, staff member, or volunteer of the organization to act as the authorized representative, there must be a new standard agreement.

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- An authorized representative appointment must not be transferred or reassigned to another individual or organization unless the applicant or beneficiary authorizes it.

By signing below, I certify that:

- I will obey all state and federal laws for authorized representatives. These include, but are not limited to, laws about confidentiality of information, prohibitions against reassignment of provider claims, and conflicts of interest.
- If I am an employee or a contractor for a health care provider or facility, I will give the applicant or beneficiary a written disclosure regarding:
    - My employment by or contract with the health care provider or facility.
    - Any potential conflicts of interest that may exist due to that employment or contract.

By signing below, I certify under penalty of perjury under the laws of the State of California that the above is true and correct.

Please complete and sign below for each person:

Name of person to act as authorized representative:	Phone number:

Signature of person to act as authorized representative:	Date:

Name of person to act as authorized representative:	Phone number:

Signature of person to act as authorized representative:	Date:

Name of person to act as authorized representative:	Phone number:

Signature of person to act as authorized representative:	Date: