

APPOINTMENT OF REPRESENTATIVE

SECTION I. TO BE COMPLETED BY APPLICANT/PARTICIPANT

Name	Person ID	Date
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I appoint this individual _____ / _____
Name of individual *Name of organization*

Complete address _____ Telephone number _____

as my authorized representative to accompany, assist, and represent me in my application for, or redetermination of, Healthy San Francisco (HSF) program benefits.

THIS AUTHORIZATION ENABLES THE ABOVE NAMED INDIVIDUAL TO:

- . Submit a Healthy San Francisco application for program enrollment.
- . Submit required verifications documents for Healthy San Francisco program enrollment, such as:
 - Proof of Identification
 - Proof of San Francisco residency (dated within 45 days of the application)
 - Proof of income (dated within 45 days of the application)
 - Proof of assets (dated within 45 days of the application)
- . Sign the Healthy San Francisco application consent and participant acknowledgement form.
- . Choose a Healthy San Francisco Medical Home.
- . Accompany me to any required face-to-face appointment(s).
- . Obtain information from HSF regarding the status of my application.
- . Receive copies of Healthy San Francisco documents such as:
 - Proof of enrollment notice
 - Next Steps Guide
 - Copies of signed documents

I UNDERSTAND THAT I HAVE THE RESPONSIBILITY TO:

- . Attend and participate in any required face-to-face appointment(s);
- . Provide all requested verifications before my eligibility can be determined; and
- . Accept any consequences of the authorized representative's actions as I would my own.

I UNDERSTAND THAT I HAVE THE RIGHT TO:

- Choose anyone that I wish to be my authorized representative.
- Revoke this appointment at any time by notifying the Healthy San Francisco program.

Applicant/Participant's signature

Date

Address

SECTION II. TO BE COMPLETED BY THE AUTHORIZED REPRESENTATIVE NAMED. *LAW FIRMS, ORGANIZATIONS, AND GROUPS MAY REPRESENT THE APPLICANT/PARTICIPANT BUT AN INDIVIDUAL MUST BE DESIGNATED AS THE CONTACT PERSON TO ACT ON THE APPLICANTS/PARTICIPANTS BEHALF.*

I HEREBY ACCEPT THE ABOVE APPOINTMENT AND UNDERSTAND THAT:

- The applicant/participant may revoke this authorization at any time and appoint another individual(s) to act as his/her/their authorized representative;
- I have no other power to act on behalf of the applicant/participant, except as stated above;
- I may not act in lieu of the applicant/participant; and
- I may not transfer or reassign my appointment without a new Appointment of Representative form being completed by the applicant/participant.

This authorization is recognized for one year from the date signed by the applicant unless revoked earlier as described in Section 1 above.

Authorized representative's signature

Employed by

Date

Telephone Number