

APPOINTMENT OF REPRESENTATIVE

SECTION I. TO BE COMPLETED BY APPLICANT/PARTICIPANT

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

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

THIS AUTHORIZATION LETS THE ABOVE NAMED INDIVIDUAL:

- Submit a Healthy San Francisco application for program enrollment.
- Submit required verifications documents for Healthy San Francisco program enrollment, like:
 - Proof of Identification
 - Proof of San Francisco residency (dated within 45 days of the application)
 - Proof of earnings (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.
- Come with me to any required face-to-face appointment(s).
- Get information from HSF about the status of my application.
- Get copies of Healthy San Francisco documents, like:
 - Proof of enrollment notice
 - Next Steps Guide
 - Copies of signed documents

I UNDERSTAND THAT I HAVE THE RESPONSIBILITY TO:

- Go to and take part in any required 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 want to be my authorized representative.
- Undo this authorization at any time by letting the Healthy San Francisco program know.

Applicant/Participant's signature

Date

Address

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

I HEREBY ACCEPT THE ABOVE APPOINTMENT AND UNDERSTAND THAT:

- The applicant/participant may undo this authorization at any time and name 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 valid 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