STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF WELFARE AND SUPPORTIVE SERVICES

DESIGNATION OF AUTHORIZED REPRESENTATIVE

Case Name: _____ Case No.: _____

I. DESIGNATION OF AUTHORIZED REPRESENTATIVE BY APPLICANT/RECIPIENT

I, _____, request the following person/agency to be:
(Print name of Applicant/Recipient)

- ☐ primary representative providing all necessary information to determine my eligibility for assistance to the Division of Welfare and Supportive Services. **Only the primary representative may sign on my behalf.**
- ☐ secondary representative who may provide information and will receive all notification regarding initial and ongoing eligibility.

I understand I may terminate this designation in writing at anytime.

_____ _____
Signature of Applicant/Recipient Date of Birth Date

_____ _____
Relationship to Applicant if signature is not Applicant (Must be family member) Date

STATEMENT OF DESIGNATED REPRESENTATIVE

I believe the above-named applicant/recipient understands the nature and consequences of his/her acts and is able to exercise his/her own will. I certify the above-named applicant/recipient made the decision to designate me as his/her representative under no threat or duress of any kind.

- ☐ As primary representative, I agree to act responsibly on behalf of the above-named applicant/recipient by providing all necessary information to determine eligibility for assistance. I understand my rights as representative are the same as if I were the applicant/recipient. I understand my obligations as responsible party are the same as if I were the applicant/recipient to the extent applicant/recipient is financially able to pay.
- ☐ As secondary representative(s), I understand I will receive all notification regarding the above-named applicant/recipient's initial and ongoing eligibility and may provide any information to assist in the eligibility process. **I understand I have no authority to sign on behalf of the above-named applicant/recipient.**

I certify under penalty of perjury, the information I provide is correct and complete to the best of my knowledge.

_____ _____
Signature of Representative Relationship (Print Name) Date

_____
Address Telephone Number

_____
Hospital, Nursing Home or County Agency

II. DESIGNATION OF AUTHORIZED REPRESENTATIVE BY OTHER

I, _____, have made a good faith effort to contact family members and/or any legal guardian of the applicant/recipient. My efforts to find a family member to act as authorized representative/provide information or a legal guardian have been unsuccessful. I therefore request to be:

- ☐ primary representative and agree to act responsibly on behalf of the above-named applicant/recipient by providing all necessary information to determine eligibility for assistance. I understand my rights as representative are the same as if I were the applicant/recipient. I understand my obligations as responsible party are the same as if I were the applicant/recipient to the extent the applicant/recipient is financially able to pay.
- ☐ secondary representative, and understand I will receive all notification regarding the above-named applicant/recipient's initial and ongoing eligibility and may provide any information to assist in the eligibility process. **I understand I have no authority to sign on behalf of the above-named applicant/recipient.**

I certify under penalty of perjury, the information I provide is correct and complete to the best of my knowledge.

_____ _____
Signature of Representative Relationship (Print Name) Date

_____
Address Telephone Number

_____
Hospital, Nursing Home or County Agency

III. ☐ This authorization ceases upon approval for Medicaid; ☐ or ceases after newborn delivery.