V075 REQ - AUTH FOR MEDICAL AGENT FOR MINOR

Our records show you are not related to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

It also does not look like you are the child's guardian, custodian,

conservator, or Social Security Payee.

We cannot work your medical application until we have proof that you

are allowed to act on this child's behalf.

If you are allowed to apply for this child, please send us copies of

any legal documents you have.

If you do not have legal documents, you must get the parent or legal

guardian of the child to complete the attached form. The form will

be used by Kansas Department of Health and Environment & Department

for Children and Families (DCF) for your medical case.

If we do not get the completed form or verification by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ we will deny the request for medical coverage.

This action is based on KFMAM 2011

We provide interpreter services at no cost.

Instructions: The **child's parent or legal guardian must complete this form entirely**. This form is only valid for one child. If the parent or legal guardian wants to appoint an authorized agent for more than one child, a completed form for each individual child is required.

This form must be signed and notarized to be valid. Copies of the

adult's legal guardianship papers are required if someone other than

the child's parent is making the appointment.

 **Appointment of Authorized Medical Agent for a Minor**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ certify

 (Full name of parent/legal guardian)

I am the parent or legal guardian of the following child.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Child's full name) (date of birth) (SSN)

The child listed above does not live with me at this time. My child

is not living with me because: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby appoint \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, an adult

 (Full name of adult caring for child)

with whom my child is residing and who has day-to-day care and control

of my child, to act in my child's behalf.

 \* I understand that I name this agent to be my child's

 representative to apply, maintain, and manage my child's

 medical assistance case with KDHE and DCF.

 \* I understand making this appointment allows this agent to

 receive any and all communications from DCF and KDHE about my

 child's medical eligibility and coverage including Protected

 Health Information. This information may include written,

 electronic or oral information related to eligibility, claims

 for benefits, and payment of benefits. I understand that

 after this information is disclosed, federal law might not

 protect it and the recipient might disclose it again. I

 I understand I have a right to a copy of this authorization.

 \* I understand naming this agent is temporary and only lasts 15 months.

 \* I understand that KDHE or DCF will review my child's medical

 case regularly and will ask for a new appointment form.

 \* I understand I may revoke this appointment at any time and that

 I may have a copy of this appointment form upon request.

 \* I understand that this authorization does not pertain to access

 for medical care from a medical facility. A medical facility

 may require that I sign an additional release to authorize the

 above named adult to obtain medical care for the child.

Print Parent or Legal Guardian's Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Legal Guardian's Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Legal Guardian's Telephone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Parent/Legal Guardian's Signature) (Date)

 **NOTARIZATION OF PARENT OR LEGAL GUARDIAN'S SIGNATURE IS REQUIRED**

State of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

County of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signed before me on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (MM/DD/YYYY)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Notary Officer

 My appointment expires: \_\_\_\_\_\_\_\_\_\_\_\_