

Application Signature & Authorized Representative Clarification

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Changes to Application Signature & Authorized Representative Guidance

- Policy has recently provided new guidance regarding acceptable signatures for valid Medicaid applications and valid designations of authorized representatives
 - » Changes involve:
 - Assistor signatures on applications
 - Designations of authorized representative
 - Signatures on applications when the authorized representative is an organization

Assistor Signature Previous Guidance

- Previously, we have provided guidance that an assistor could sign the Medicaid application and the application would be considered valid
 - »The county would have to contact the individual to verify their intent to apply for Medicaid and obtain permissions to ping the Hub and use AVS
- OAC 5160:1-2-01(G) used to state the agency must accept and register *any* signed application
 - »This rule was revised effective 12/14/2020 and the word '*any*' was removed

This previous guidance is no longer accurate

Assistor Signature New Guidance

- OAC 5160:1-2-01(G) still requires a signed application for Medicaid
- Policy has clarified that an assistor can help an individual complete an application, but the assistor cannot sign the application
 - » A signature from anyone other than the applicant or authorized representative is an incomplete application
 - Application is not valid
- If an application is received that is signed by an assistor, the county will need to contact the applicant or authorized representative and acquire a signature for eligibility to be explored
- **EXCEPTION: An assistor can still sign a Medicaid application when the applicant is deceased or incompetent with no authorized representative**
 - » The county would follow guidance under 5160:1-2-01(F)(5)

Assistor Signature New Guidance

- Policy has clarified that two unmarried adults who do not file taxes together cannot apply for Medicaid on the same application
 - » Federal regulations indicate an adult who is not part of the same tax filing household would need to submit a separate application



Assistor Signature New Guidance Example 1

Lucille helped her neighbor, Ethel, complete an application for Medicaid. Ethel is the only one applying. Lucille signs and submits the application. Lucille is not the authorized representative for Ethel.

How should the county proceed with this application?

Assistor Signature New Guidance Example 1

- The application for Ethel that was signed by Lucille is not a valid application
- Before exploring Medicaid eligibility for Ethel, the county will need to contact Ethel to obtain her signature or Ethel's designation of Lucille as her authorized representative
 - »Once Ethel's signature or appropriate authorized representative designation is obtained, Medicaid eligibility can be explored for Ethel using the initial application date
 - »If Ethel's signature or the appropriate authorized representative designation is not obtained, Medicaid eligibility cannot be explored for Ethel
 - The county will need to perform a Negative Action using the Administrative Closure reason to deny the block
 - A NOA should not be issued for incomplete applications

Assistor Signature New Guidance Example 2

Martin applied for Medicaid for himself and his girlfriend, Gina. Martin provided a signature and stated that he files taxes as single with no dependents. Martin was unsure about how Gina files her taxes. Martin is not the authorized representative for Gina.

How should the county proceed with this application?

Assistor Signature New Guidance Example 2

- The application that Martin submitted for himself is valid
 - »The county should process the application for Martin as normal and explore his Medicaid eligibility
- The application signed by Martin is not a valid application for Gina
 - »Gina is not a part of Martin's tax filing household
 - »Gina would need to apply for herself
 - »The county would need to contact Gina to inform her that she will need to submit a separate application for herself



Who Can Do What?

Updated April 2021	Authorized Representative	Healthcare Power of Attorney	Financial Power of Attorney (Must grant authority to apply for government benefits)	Assistor	Guardian
Can sign application for Medicaid individual				¹	
Can provide information about the Medicaid individual to the agency					
Can name a different person as an authorized representative			 Only if specifically detailed in POA document		
Can receive information about the Medicaid individual without a signed release of information					
Can grant permission to ping the hub and access AVS					

¹ An assistor can still sign a Medicaid application when the applicant is deceased or incompetent with no authorized representative. The county would follow guidance under 5160:1-2-01(F)(5) to process the application.

Authorized Representative (AR) Designations

- OAC 5160-1-33 discusses the designation and responsibilities of the authorized representative
- OAC 5160:1-2-01(F)(2) discusses the agency's responsibilities relating to authorized representatives
- Policy recently provided expanded guidance on the designation of an authorized representative

Authorized Representative (AR) Designations Previous Guidance

- Previously, we have provided guidance stating that an individual must designate an authorized representative in writing
 - »The ODM 06723 Designation of Authorized Representative form could be used to make the designation but was not required
 - »A written statement listing the duties the authorized representative can perform could be used to make the designation
 - »The designation had to be signed by the individual
- All were considered valid AR designations

Authorized Representative (AR) Designations Expanded Guidance

- Policy has provided expanded guidance for when an authorized representative designation is considered valid

»What remains the same:

- The ODM 06723 Designation of Authorized Representative form is recommended but not required
- If another form or written statement is used, the designation must identify the duties of the authorized representative

Authorized Representative Designations Expanded Guidance

- What has expanded:
 - »The designation must state that the authorized representative agrees to maintain or be legally bound to maintain the confidentiality of any information regarding the individual provided by the administrative agency – OAC 5160-1-33(B)(2)
 - »If the authorized representative is an organization, the designation must state that the authorized representative affirms that he or she will adhere to the regulations in 42 C.F.R. Part 431 Subpart F (as in effect October 1, 2015), 42 C.F.R. 447.10 (as in effect October 1, 2015), 45 C.F.R. 155.260(f) (as in effect October 1, 2015), as well as other relevant state and federal laws concerning conflicts of interest and confidentiality of information – OAC 5160-1-33(E)
 - »The designation must be signed by the individual and authorized representative
 - »Protected Health Information (PHI) cannot be disclosed to the authorized representative unless the individual had completed and signed the Authorization of the Use and Disclosure of Protected Health Information section of the ODM 06723 form

Authorized Representative Designations Expanded Guidance

- The authorized representative designation is considered incomplete (not valid) if it is missing any of the following information:
 - » Individual's signature
 - » AR's signature
 - » Duties the AR can perform
 - » Agreement that the AR will maintain the individual's confidentiality
 - » Agreement that the AR will adhere to regulations and laws concerning conflicts of interest and confidentiality of information if the AR is an organization

Authorized Representative Designations Expanded Guidance

- What happens if the county receives an incomplete authorized representative designation?
 - » This is not a valid AR designation
 - » The designated person cannot be added to the case as the AR or provided with any case information, checklists, notices, etc.
 - The agency can still accept information from the designated person as an assistor
 - » The county would need to send the ODM 06723 form to the individual to obtain the missing information
 - Once the missing information provided, the designated person can be added to the case as the AR
 - If the missing information is not provided, the designated person cannot be added to the case as the AR

Authorized Representative Designations Expanded Guidance

- What happens if the county receives a completed authorized representative designation but there is no authorization to disclose PHI?
 - » This is a valid AR designation
 - The individual is not required to grant the AR access to his/her PHI
 - The designated person can be added to the case as the AR
 - The AR will still receive case information, including NOAs and other correspondences
 - » The AR will not be able to access PHI for the individual
 - PHI includes medical records and information about services/treatments
 - » If the individual wishes to allow the AR to access the PHI, the county would need to send the ODM 06723 to the individual to complete and sign page 2

ODM 06723 Designation of Authorized Representative Form

- The ODM 06723 Designation of Authorized Representative form and instructions for completing the form are available on the Medicaid website

»Instructions:

<https://www.medicaid.ohio.gov/Portals/0/Resources/Publications/Forms/06723i.pdf>

»Form:

<https://www.medicaid.ohio.gov/Portals/0/Resources/Publications/Forms/ODM06723fillx.pdf>

Signature on Application When AR is an Organization

- Policy has recently clarified that when the AR is an organization and the AR signs the application, the signature must be the name of the actual organization employee who completed the application and not the name of the organization
 - »The AR cannot sign the application with the name of the organization (i.e., Medassist, HumanArc, Hospital Referral Services)
- If an application is received with the organization name listed as the signature, the county would need to send a new signature page to the AR requesting the signature of the person who completed the application
 - »Once the new signature page is obtained, eligibility can be explored for the individual using the date the initial application was received

Snippet of AR Form Designating an Organization as the AR

I, INDIVIDUAL'S NAME HERE, ("Applicant") appoint Firstsource Solutions USA, LLC dba MedAssist and its employees ("MedAssist") to act as my Designated Representative for the purpose of pursuing financial assistance for my medical expenses and additional programs, government, hospital or otherwise, for which I may be eligible. As my Designated Representative, MedAssist is authorized to act responsibly on my behalf to accompany, assist, and represent me in my application for or redetermination of benefits with any agency or entity that offers such support ("Agency" or "Agencies"). Agency or Agencies may include, but are not limited to, local, state, and federal funding sources such as hospital charity, county human services, Medicaid, and Social Security Administration. I understand that MedAssist receives payment from my healthcare provider, such as a hospital where I received treatment, to provide these financial assistance services on my behalf. I understand that I may change my mind and/or withdraw from applying to financial assistance programs at any time. I will provide MedAssist with my most current contact information so that MedAssist can keep me informed and engaged during the application process and any subsequent related matters.

The portion outlined in red shows that an organization has been named as the AR. The county can request identification to verify an individual is an employee of the organization before disclosing information – OAC 5160-1-33(B)(1).

Snippet of AR Form Designating an Organization as the AR

The signature page of the AR form should have the signature of the individual and the signature of an employee of the organization

INDIVIDUAL'S SIGNATURE HERE	
_____ <i>Applicant Signature</i>	_____ <i>Date</i>
<i><u>If signed by an individual authorized by law to sign on behalf of the Applicant:</u></i>	
_____ <i>Legal Representative's Signature</i>	_____ <i>Date</i>
<i>Description of Legal Representative's Authority (such as legal guardian):</i> _____	

AS THE DESIGNATED REPRESENTATIVE, MEDASSIST WILL PROTECT AND MAINTAIN THE CONFIDENTIALITY OF ANY INFORMATION PROVIDED BY THE AGENCY TO MEDASSIST, INCLUDING INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION AND FINANCIAL INFORMATION OF THE APPLICANT, PURSUANT TO THE REGULATIONS SET FORTH IN 42 CFR 435.923; 42 CFR 431 SUBPART F; 45 CFR 155.260(f), 42 CFR 447.10, AS WELL AS OTHER RELEVANT STATE AND FEDERAL LAWS.	
ORGANIZATION'S EMPLOYEE SIGNATURE HERE	
_____ <i>Authorized Employee Signature</i>	_____ <i>Date</i>

Example of an Unacceptable Signature on the SSP Application

Authorized Representative		
Name	Program	Assisting Organization
MEDASSIST, ALL	Medicaid	MEDASSIST
▶ Other Health Care		
▶ Third Party Liability		
▶ Counselor Information		
e-Signature Information		
Applicant Role Description: Applicant	Signed with PIN: No	Signature: MEDASSIST



If application is signed by an AR that is an organization, the Applicant Role Description should be 'Non-Applicant' and the Signature should be the name of the organization employee who completed the application

Example of an Unacceptable Signature on the SSP Application

Did anyone help you complete this application? : Y

If yes:

Please tell us more information about who helped you complete the application:

Name of Person: MEDASSIST MEDASSIST

Name of Organization: MEDASSIST Organization Type: Other Type of Organization

Phone Number: (740)383-8598

E-mail:


Address Line 1: 1000 MCKINLEY PARK DR

Address Line 2:

City: Marion

State: OH

Zip Code: 43302



The name of the organization employee who completed the application should be listed here

Example of an Unacceptable Signature on the SSP Application

I declare under penalty of perjury under the laws of the United States of America that the information contained in this statement of facts is true, correct and complete. This page should capture the user e-signature or if non-applicant completed the application, this page needs to capture the following:

Signature : Signature : MEDASSIST MEDASSIST
Description: Authorized-Representative
Confirmation Number: 002jrfv2

X INCORRECT

Please complete the information below about yourself:

Relationship to applicant:
First Name:
Middle Name:
Last Name:
Suffix:

The name of the organization employee who completed the application should be listed in the Signature field and the Description field can identify the person signing as the AR

The person signing the application should complete the 'Please Complete the Information Below About Yourself' section

E-application Signature Information

e-Signature Information			
Applicant Role Description: Non-Applicant	Signed with PIN: No	Signature:	
First Name:	Middle Name:	Last Name:	Suffix:
Relationship to the Applicant: Other	Home Phone Number:	Other Phone Number:	Email:
Address Line 1: .	City:	State: OH	Zip:
Address Line 2:			

The information about the person completing the application can be found in the yellow boxes if this information is completed on the E-app. The red boxes indicate someone other than the applicant signed the application. It will be important to check this information to determine if the application has a valid signature.

7216 Application Signature Information

Sign this application. The person who filled out Step 1 should sign this application. If you're an authorized representative you may sign here, as long as you have provided the information required in Appendix C.

Signature	Date (mm/dd/yyyy)
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Signature page of 7216 (page 8) instructs the AR to complete Appendix C (page 14) of the 7216

APPENDIX C

Ohio Department of Medicaid
ODM07216 - C (7/2014)

Assistance with Completing this Application

You can choose an authorized representative.

You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact your local County Department of Job and Family Services. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name, Suffix)		
2. Address		3. Apartment or suite number
4. City	5. State	6. ZIP code
7. Phone number () -		
8. Organization name		9. ID number (if applicable)
By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with this agency.		
10. Your signature		11. Date (mm/dd/yyyy)

For certified application counselors, navigators, agents, and brokers only.

Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)	
2. First name, Middle name, Last name, & Suffix	
3. Organization name	4. ID number (if applicable)

It will be important to check this information to determine if the application has a valid signature

7200 Application Signature Information

5. Tell us if you are an authorized representative

An authorized representative is someone who assists the applicant by completing the application process. If you are filling out this form as an authorized representative, please fill out the following.

First Name		Middle Initial	Last Name	
Street Address				
City		County	State	Zip Code
Phone Number ()	Best Time to Call	Additional Phone Number ()	E-mail Address	

6. Sign Here

Signature of Applicant or Authorized Representative	Print
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12. Signature of person who completed this application

By signing this application:

- I understand the questions on this form and certify, under penalty of perjury, that all my answers are correct and complete to the best of my knowledge, including information about the citizenship or alien status of each household member applying for assistance.
- I state under penalty of perjury I have disclosed all annuities and other similar financial devices in which I and/or my spouse have any interest.
- I understand and agree to provide documents to prove what I have said.
- I understand and agree that the CDJFS may contact other persons or organizations to obtain the necessary proof of my eligibility and level of assistance.
- I understand that by signing this application and receiving Ohio Works First, I am assigning to the State of Ohio any rights to child/spousal support that is owed to me and/or the minor children in the assistance group during the Ohio Works First eligibility period.
- I understand that by signing this application and receiving Medicaid, I am assigning to the State of Ohio any rights to medical support and any rights to payments by a liable third party for medical assistance owed to me and/or to the minor children in the assistance group during the Medicaid eligibility period.
- I understand that I may be required to cooperate with the child support enforcement agency in establishing paternity or establishing or enforcing a support order. If I am required to cooperate with the child support enforcement agency, a referral will be submitted to the agency on my behalf. I also understand that if I am not required to cooperate with the child support enforcement agency, I may request child support services by completing the JFS 07076 "Application for Child Support Services."
- I understand that in some instances, I may be asked to give consent to the CDJFS to make whatever contacts are necessary to determine my eligibility.
- I understand if I receive cash assistance on the electronic payment card that I must activate my card within 90 days from when benefits and my first card is issued. If the electronic payment card is not activated within 90 days my benefits will be removed from my account.

Signature of Applicant or Authorized Representative	If Authorized Representative, Relationship to Applicant	Date

AR information can be listed in Section 5, but a separation AR designation still required. Section 12 must be signed.

It will be important to check this information to determine if the application has a valid signature

Renewal Packet Signature Information

Sign and date below. If you want an authorized representative or want to change the authorized representative you have now, fill out Attachment A on page 10. The last page is a Voter Registration Form and is not part of your Medicaid renewal. If you wish to register to vote, fill that form out and return it separately to your county board of elections.

Check here if you are an authorized representative. Sign below and fill out Attachment A on page 10.

Signature of household contact or authorized representative:	Date:
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Signature page of renewal packet (page 9) instructs the AR to check the box and complete Attachment A on page 10 of the renewal packet

Attachment A Assistance with completing this renewal form

You can give a trusted person permission to talk about this renewal form with us, see your information, and act for you on matters related to this form, including getting information about your renewal and signing your form on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact your local County Department of Job and Family Services. If you're a legally appointed representative for someone on this application, submit proof with this form.

If you have an authorized representative now, please answer these questions.

We show that you chose this person as your authorized representative: Do you still want this person to be your authorized representative
 Yes No
 If yes, has any of his or her information changes?
 Yes No

If your authorized representative's information has **changed**, or if you would like a **different** authorized representative, please write the new information below:

Name of authorized representative: _____

Address: _____ Apartment # _____ City _____ State _____ Zip code _____

Phone number: Home Cell Work Other
 Number: _____

By signing, you allow this person to sign your renewal form, to get information about this renewal form, and to act for you with this agency.

Your signature: _____ Date: _____

If you do not have an authorized representative and want one, please answer these questions.

Check here if you are an authorized representative. Answer the questions below.

Name of authorized representative: _____

Address: _____ Apartment # _____ City _____ State _____ Zip code _____

Phone number: Home Cell Work Other
 Number: _____

By signing, you allow this person to sign your renewal form, to get information about this renewal form, and to act for you with this agency.

Your signature: _____ Date: _____

It will be important to check this information to determine if the renewal has a valid signature

Entering an Organization as AR in OB

- To add an AR to the case, follow the steps listed in the Administrative Roles job aid located on the OB Project website:

<https://ohiobenefitsproject.ohio.gov/Asset/Search/id/29/xmps/1759>

»Enter the last part of the organization’s name as the last name and then enter the first part of the organization’s name as the first name

- Organization Name: Helping Hands
 - Last name entered as Hands
 - First name entered as Helping
 - NOTE: Gender is not required

Search

New Person Search

* - Indicates required fields
 ▲ -Indicates required fields for SOL-Q Verification

Last Name: * ▲	First Name: * ▲	Middle Name/Initial:	Person Identifier:	Suffix:
<input type="text" value="Hands"/>	<input type="text" value="Helping"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="v"/>
Social Security Number: ▲	Date of Birth: ▲	Alien Number:	Billing Number:	Gender:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="v"/>
Recipient ID:				
<input type="text"/>				

Entering an Organization as AR in OB

- After completing the remaining steps in the Administrative Roles job aid, the AR will be listed on the Case Summary screen

Medicaid - MC 02 - [REDACTED]

<p>Worker:</p> <p>Worker ID:</p> <p>Program Status: Active</p> <p>RE Due Month: 09/2021 Re-Evaluate</p>	<p>Primary Applicant/Recipient: Mickey Mouse</p> <p>Spoken Language: English</p> <p>Phone Number: [REDACTED] 📞</p> <p style="border: 2px solid red;">Authorized Representative: Helping Hands</p> <p>Application Date: 07/01/2016</p>
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Name	Requested Medicaid Type	Role	Role Reason	Status	Status Reason	Referred to FFM
▶ Mickey Mouse	LTC	MEM		Active		No

View Details

Questions

