# Designation of Authorized Representative

This is my designation of _____ as my authorized Representative under 42 C.F.R. § 435.923(a) with full authority to assist in filing an application for Medicaid and any request for a fair hearing, and to assist with any and all other matters relating to my application for Medicaid. I hereby certify that I am either signing for myself or that I am an individual or entity accorded authority to act on behalf of the applicant or beneficiary under state law, including but not limited to, a court order establishing legal guardianship or a power of attorney.

Name of Applicant: _____

_____
**Applicant's signature**

Or

_____
An individual or entity accorded authority to act on behalf of the applicant or beneficiary under state law

**Printed name**: _____

**Basis for authority**:

- ☐ Community Spouse
- ☐ Agent under Power of Attorney
- ☐ Guardian
- ☐ Conservator
- ☐ Agent under Health Care Advance Directive, see O.C.G.A. § § 31-32-7(e)(3)
- ☐ Default Health Agent under O.C.G.A. § 31-9-2(a)