P.O. Box 3599
Topeka, KS 66601-9738
Phone: 1-800-792-4884

Facilitator Authorization Form

Consumer Name: ___________________________ Consumer ID or SSN: ________________________________

You can name a person to help you with your medical assistance application. This form is used to appoint a Facilitator.

A **Facilitator** is a person or organization who can help you fill out your application and help you through the application process. You remain in charge of your case. We will be able to share information with this person. They will get copies of letters sent to you about your application. You have the option to tell us how long you want the information to be shared (see below). This release will stay in effect until your application is completed. A Facilitator can be a relative, neighbor, friend, medical office staff, or community organization employee.

They cannot make requests for coverage for you.

First and Last Name					
Organization Name					
Address Line 1					
Address Line 2					
City		State		Zip Code	
Phone Number		Email Address			
What is this person's relationship to you? (For example: child, friend, neighbor, medical provider, community organization, etc.)					

I authorize the use or disclosure of my health information by the person named above to KDHE-DHCF, DCF, and KDADS.
I understand that I have the right to revoke this authorization at any time by notifying KDHE-DHCF.
I understand that after this information is disclosed, federal law might not protect it and the recipient might disclose it again.
I understand that I am entitled to a copy of this authorization.
I understand that I may decide whom KDHE-DHCF speaks to by providing my initials below. If you wish for KDHE-DHCF to assign a single Facilitator role for the organization, this will allow us to speak with anyone from that organization at the specified office location.

- If you would like KDHE-DHCF to speak only to the individuals who you have listed above, please initial here _____.
- If you would like KDHE-DHCF to assign a single Facilitator role for the organization, please initial here _____.

I understand that this authorization will expire 6 months from the date this form is signed or once my application is completed, whichever is later. I choose to provide a different date for the expiration of this release:______________.
An appointment of a community organization, a medical provider, or staff cannot exceed 12 months.

My signature on this form signifies that I have read and understand the conditions above.

Signature:____ Date: _________________________

Witness signatures required if the signature above is made with a mark.

Witness:____ Date: _________________________

Witness:____ Date: _________________________

Fax completed form to: Family Medical programs 1-800-498-1255 or Elderly & Disabled Medical programs 1-844-264-6285