Financial Counseling Unit
Contra Costa Regional Medical Center
2500 Alhambra Avenue
Martinez, CA 94553

Appointment of Authorized Representative

Please use this form to appoint an individual or organization as your authorized representative for the Basic Health Care (BHC) Program or any other Contra Costa Health-sponsored program. Your authorized representative may act for you on all duties related to your BHC eligibility and enrollment. You may limit the duties of your authorized representative, as well as cancel or change this appointment at any time.

Please include this form with your enrollment application if applicable.

Part A – Tell us about you:

Applicant Name:	Phone Number:	Email:

Mailing Address (number, street, state and ZIP Code):

Part B – Tell us about your Authorized Representative:

Name of Authorized Representative (Individual or Organization):	Phone Number:

Mailing Address (number, street, state and ZIP code):

Email:

Part C – Examples of Authorized Representative Duties:

- Assist applicant with completing and signing the application.
- Sign the application on behalf of the applicant.
- Provide information to CCHS upon request to finalize the application process.
- Report to CCHS changes to the applicant's status.
- Assist with the appeals process in the event the application is denied.

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Please use this section to describe how you want to limit the duties of your authorized representative:

My authorized representative may not do the following duties:

Part D – Please read the following and sign:

I. **Applicant:** By signing below, I appoint the individual or organization named in Part B as my authorized representative. Additionally, I agree that:
   a. The authorized representative may perform duties on my behalf (see Part C).
   b. This authorization starts on the date I sign this form.
   c. My rights and responsibilities do not change because I have an authorized representative.
   d. I must make sure I respond to all requests for information.
   e. The authorized representative may cancel this appointment at any time.
   f. I may contact CCHS – Financial Counselling Unit in writing at any time to change or cancel this appointment.

II. **Authorized Representative:**
   a. You may contact CCHS – Financial Counseling Unit in writing to cancel this appointment at any time.
   b. You agree to keep confidential any information about the applicant that you receive for the purposes of enrollment in the BHC Program or any related CCHS sponsored program for which the applicant may be eligible.

By signing below, I agree to and understand my rights and responsibilities as stated above:

Signature of Applicant:	Date:

Signature of appointed Authorized Representative:	Date: