State of Illinois
Department of Human Services
Department of Healthcare and Family Services

APPROVED REPRESENTATIVE FORM

Date: _____

Case Number:
(if known) _____

a96ffb79-884e-417b-a97a-68b78bb760f7

Use this form if you want someone to act on your behalf with the Department of Healthcare and Family Services or the Department of Human Services for Cash, SNAP and Medical benefits

- **INSTRUCTIONS FOR COMPLETING THIS FORM:**

- Appoint an Approved Representative: Complete Section A (the Applicant/Client Information section) and complete, sign, and date Section B (the Applicant/Client Permission section) on Page 2. Have your Representative complete, sign, and date Section C (the Representative section) on Page 3.
  - If you have a power of attorney or a court order establishing a legal guardianship, you should send that legal document with this form.
  - An applicant living in a drug or alcohol facility must have an approved representative to apply for and receive SNAP benefits.
  - You should not have to pay anyone to help you apply for benefits.

- Health Information: Federal law says that we cannot share your health information without your permission except in certain situations. If you complete, sign, and return this form, you are giving us permission to share your health information with the person or organization you name as your Approved Representative. More information about our privacy practices is available at http://www2.illinois.gov/hfs/SiteCollectionDocuments/0921063806.pdf and http://www.dhs.state.il.us/onenetlibrary/12/documents/Forms/IL444-4775.pdf

- Right to Cancel: You may stop this person or organization from acting as your Approved Representative at any time. If you decide you no longer want this person or organization to act on your behalf, complete Section A (the Applicant/Client Information section) and complete, sign, and date Section D (the Cancel My Approved Representative section). This change will take effect after we receive the signed request from you.

- **Keep a copy of this form for your records**. A blank copy of this form is also available at http://www.dhs.state.il.us/onenetlibrary/12/documents/Forms/IL444-2998.pdf or http://www.hfs.illinois.gov/hipaa/forms.html.

- **HOW TO DESIGNATE AN APPROVED REPRESENTATIVE -** Use one of the 3 easy ways below

1. You can assign an Approved Representative online. Go to https://abe.illinois.gov and approve a Representative when completing the application or add one through Manage My Case - Report My Changes - Change in Contact Information, add text, submit change and upload this form; or

2. Fill out, sign, and send this form by mail or fax to:
   a. Mail to State of Illinois, P.O. Box 19138, Springfield, IL 62794-9138 or
   b. Fax to 1-844-736-3563.
3. You can return this form in person to your local Family Community Resource Center.

- Requests to Cancel My Approved Representative on this form may be returned as indicated above.

- If you have questions about this form, email them to: DHS.ABE.Questions@Illinois.gov , or call 1-800-843-6154.

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SECTION A

APPLICANT/CLIENT INFORMATION: Complete this section if you are the client or the applicant.

Applicant/Client's Name: _____ Date of Birth: _____

Address: _____

Telephone Number: _____

Social Security Number (not required): _____ Recipient I.D. or Case Number: _____

Name of Approved Representative: _____

Relationship of Representative to Applicant/Client: _____

I want to (check only one box):

- ☐ Appoint a new Approved Representative
- ☐ Cancel my Approved Representative (skip Sections B and C and go to Section D (Cancel My Approved Representative) on Page 3).

SECTION B

APPLICANT/CLIENT PERMISSION: Complete, sign, and date this section if you are the client or the applicant.

Item	Things I want my Approved Representative to do for me
All Matters	• Act on my behalf in all matters, including all items listed below. (**Note: This Approved Representative Form does not authorize representation for Appeals.** To authorize a representative for appeals, please submit a separate, written authorization when filing the appeal).
Application for Benefits	• Complete, sign, and submit an application for benefits. • Receive and submit information about the application.
Continuing Eligibility	• Complete, sign, and submit redeterminations. • Receive and submit information about the redetermination • Report changes in my circumstances that may affect my eligibility.
Health Information	• Receive copies of all notices about my benefits. • Request information (both oral and in writing) relating to my healthcare. • I give permission to the Departments to share my health information (including information related to substance abuse, mental health, genetic testing information, and HIV/AIDS) with the Approved Representative.
Health Plan Enrollment and Disenrollment	• Request and receive education and information regarding managed care programs and health plans. • Act on my behalf to enroll with, switch to or dis-enroll from a managed care health plan and/or primary care provider (PCP), as allowed by the program.

By signing below, I give permission to the Approved Representative to act for me for the items above. I understand that I am responsible for the information my Approved Representative gives the Departments, including any information that may be incorrect. I also understand that I must complete a request to cancel any Approved Representative that I no longer want to act on my behalf.

Client's Signature: _____ Date: _____

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SECTION C

REPRESENTATIVE SECTION: Complete, sign, and date this section if you are the Representative.

Notice to Approved Representative: It is a Class C misdemeanor for any person or organization to charge an applicant or client a fee for certain services. *See* 305 ILCS 5/8A-18 and 20 ILCS 2225/5.

Check only one box:

☐ I am an individual representing the client or applicant. Complete 1, 2, 3 and 4a.

☐ I am with an organization representing the client or applicant. Complete 1, 2, 3 and 4b.

1. Representative Name: _____

2. Representative Address: _____

3. Representative Telephone Number: _____

4a. I agree to adhere to the regulations in 42 CFR Part 431, Subpart F and at 45 CFR 155.260(f) (relating to confidentiality of information), 42 CFR 447.10 (relating to the prohibition against reassignment of provider claims as appropriate for a facility or an organization acting on the facility's behalf), as well as other relevant State and Federal laws concerning conflicts of interest and confidentiality of information

Representative's Signature: _____ Date: _____

4b.

Name of Individual completing this section and signing below: _____

Name of Organization: _____

I agree that I have authority to represent the Organization listed above. I also agree, on behalf of the Organization, that such organization will adhere to the regulations in 42 CFR Part 431, Subpart F, 45 CFR 155.260(f) (relating to confidentiality of information), 42 CFR 447.10 (relating to the prohibition against reassignment of provider claims as appropriate for a facility or an organization acting on the facility's behalf), as well as other relevant State and Federal laws concerning conflicts of interest and confidentiality of information

Signature on behalf of
Organization Representative: _____ Date: _____

SECTION D

CANCEL MY APPROVED REPRESENTATIVE SECTION

Instructions to the Applicant/Client:

- You should complete this section ***only if*** you no longer want your Approved or Organization Representative to act on your behalf.
- Complete, sign, and date below and submit this form according to the instructions on page 1.
- **You must also complete Section A on page 2.**

I no longer want the person or organization named below to act as my Approved Representative.

My Name: _____

Name of Approved or Organization Representative: _____

Signature: _____ Date: _____