Authorization for Designated Client Representative

Read this information first:

You should complete this form if you wish to authorize someone to act on your behalf to file a complaint (grievance) or an appeal. This will allow the assigned person acting as your Designated Client Representative (DCR) to contact Northeast Health Partners and speak to us on your behalf.

Mail this form to: P.O. Box 31364 Salt Lake City UT 84131-0364

Step 1: Complete the demographic information for the person receiving services:

1. _____ **2.** __ __ / __ __ / __ __ __ __
Name **Date of Birth**

3. _____ **4.** (__ __ __) __ __ __ - __ __ __ __
Address **Home Phone Number**

Step 2: Tell us the reason for the Designated Client Representative:

7. Check the appropriate box to indicate the reason you are assigning a DCR:

a. Designated Client Representative for an Appeal ☐

b. Designated Client Representative for a Complaint ☐

Step 3: Tell us who you are authorizing to act as your Designated Client Representative:

8. _____
Name of Authorized person

9. _____
Address of Authorized person

10. OPTIONAL: authorization termination date: __ __ / __ __ / __ __ __ __

Step 4: By filling out and signing this form, you understand that:

- You do not have to complete this authorization and your refusal will not affect your benefits;
- The information used or disclosed by this authorization may be at risk for re-disclosure by the recipient and no longer protected by federal privacy laws;
- You have a right to revoke this authorization at any time by informing us in writing;
- You have a right to receive a copy of this signed authorization.

12. _____ _____
Person receiving services* Date

13. _____ _____
Parent and/or Guardian (if applicable) Date

14. _____ _____
Designated Client Representative's relationship** Date

***Minor Children must sign this form if they are 15 years of age or older.**

****Parents cannot sign for minor children 15 years of age or older.**