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MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

AUTHORIZED REPRESENTATIVE ORGANIZATION DESIGNATED CONTACT

42 CFR 435.923(e) requires, the employee of the organization shall affirm and agree that, as a condition of serving as an authorized representative, that he/she will adhere to Section 208.155 RSMo, 42 CFR 431(f), and 45 CFR 155.260(f), 42 CFR 447.10, as well as other relevant State/Federal laws concerning conflicts of interest and confidentiality of information. The organization shall provide in writing the name, address and phone number of an individual within the organization who shall serve as a contact person with the Division within ten (10) days of appointment of the organization as the authorized representative. **The organization shall notify the division in writing of any change in the name and contact information for the contact person within ten (10) days of the change.**

NAME OF ORGANIZATION

ADDRESS

TELEPHONE NUMBER

Designates the individual listed below to be the contact person on behalf of the above organization:

NAME

TELEPHONE

ADDRESS

The individual listed above will act as the authorized representative for:

NAME

SSN OR DCN

ADDRESS

TELEPHONE

I, _____
(PRINT NAME OF SUPERVISOR)

Telephone number (_____) _____ , **attest the above listed contact person is a member or employee of the organization listed above and is acting with the authority of the organization.**

SUPERVISOR SIGNATURE	DATE

IM-6ARO INSTRUCTIONS
AUTHORIZED REPRESENTATIVE ORGANIZATION DESIGNATED CONTACT (MO HealthNet Programs)

Purpose: To provide a signed statement that designates an individual with in an organization as a contact person for the Family Support Division.

This form should be completed if an organization is designated as the authorized representative for an applicant/participant of MO HealthNet programs to provide the Family Support Division with a contact person within the organization.

This form does not authorize an authorized representative access to protected health information that may be contained in a record with the Family Support Division. If applicant/participant wishes to have protected health information released to their authorized representative, they must request this release and disclosure of information by completing the Department of Social Services HIPAA compliant release form 650-2616 (HIPPA) Authorization of Disclosure of Consumer Medical/Health Information.

Number of Copies and Distribution: This form is available in hard copy or PDF. The original is completed by the supervisor of the contact person within the organization that has been appointed as an authorized representative. This form is filed in the record as a permanent part of the record. A copy of the original must be given to the applicant/participant.

Instructions for Completion of AUTHORIZED REPRESENTATIVE ORGANIZATION DESIGNATED CONTACT: The form is completed by the supervisor of the contact person.

The supervisor **must** complete the form as follows:

- Print the organizations name, telephone number, and address.
- Print the name, telephone number, and address of the individual designated as the contact person.
- Print the applicants/participants name and DCN or SSN.
- Print the name of the supervisor filling out the form and sign and date.