

Call Center Resource Desk Authorization Representative Forms

Subject: Designated Authorization Representative Form Process	Effective Date:
Section: Call Center Resource Desk	Revision Date: September 2020
Author: Lisa Payne	Title: Call Center Supervisor
Approved by: Patrick McNutt	Title: Call Center Manager

Accountability

Call Center Agents
 Call Center Leads
 Call Center Supervisors
 Call Center Manager

Definitions and Acronyms

AHS: Automated Health Systems
 AHCA: Agency for Health Care Administration
 CC: Call Center Agent
 CCS: Call Center Supervisor
 CCL: Call Center Lead
 DAR: Designated Authorized Representative Form
 DCF: Department of Children & Families
 P&P: Policy and Procedures

Policy

The general purpose of this P&P is to outline the procedure AHS will use to comply with the general provisions required to timely and accurately handle all incoming Authorization forms by call center staff for the Statewide Medicaid Managed Care Program. The specific purpose of this procedure is to record, track, and process Designated Authorized Representative forms (DAR) and legal authorization documents such as Power of Attorney, Legal Guardianship and Health Care Surrogate/Proxy forms received from SMMC callers.

Entry Point

Authorized representative forms may be received via postal service, email or e-fax .

a. P.O. Box

- i. A member of the mailroom drives the mailroom van to P.O. Box 5197 Tallahassee FL, 32314 to retrieve documents and bring them to the mailroom to process.
- ii. The DAR forms are given to a designated Document Services Specialist for complete handling of the forms from opening, scanning, date stamping, notification sent to call center supervisor, lead and designated agents trained to process these forms. Once that has been completed they are secured in a locked filing cabinet location inside the secured entry and camera monitoring Mailroom for 90days prior to destruction by our authorized Recycle vendor where this is also handled by the Document Service Specialist that handles the form process or a member of management.
- iii. The document is scanned into the M-Drive to be worked by a member of the Resource Desk.

b. Email

- i. Documents are sent to us at Flenrollmentrequest@automatedhealth.com.
- ii. The document is marked approved or rejected and uploaded to the appropriate case and the case is notated.

c. E-Fax

- i. Documents are sent to us via E-fax at 850-402-4679 and 850-402-4678.
- ii. The document is marked approved or rejected and uploaded to the appropriate case and the case is notated.

Processing

1. The CC will work the oldest authorization documents first to ensure all are worked within 48 hours
2. The CC will open DAR document and verify if the information is complete:
 - a. Recipient information is considered to be complete; when it has: Last Name, First Name (middle initial is not a required entry), Medicaid ID number (may be gold card or full Social Security Number of member), year of birth (YOB) and the relationship to the representative.
 - b. Representative information must be complete, such as: printed name, address, phone number, government issued ID number, date and last five digits of their Social Security Number (SSN optional).




- c. Witness must print and sign their name. Anyone other than the authorized representative 18 years of age or older can be a witness. The print name, sign name, and date fields must be completed.
 - d. Review HealthTrack to determine whether there is another authorization type on file for the enrollee. If there is an additional authorization, compare the information on the DAR against the other authorization type.
 - i. Is the name on the DAR the same as the Power of Attorney or Guardianship form?
 - ii. If the POA or guardianship form has a facility, law firm or other entity listed, but not an actual name, does the DAR reflect the name of a person representing the entity? The representative's name and entity must be on the DAR. The address of the facility on the DAR must match the facility address on the POA or guardianship form.
 - iii. If the information on the POA or guardianship does not match, the DAR is to be rejected and a call back is made to request an updated POA or DAR based on why it is rejected. The call back will be completed within 48 hours.
 - e. If an expiration date is not provided on the DAR, it will expire one year from the date it is received.
- 3. The CC will open POA, Guardianship or Healthcare Surrogate document and verify if the information is complete:
 - a. Recipient information is considered to be complete; when it has: Last Name, First Name (middle initial is not a required entry), Medicaid ID number (may be gold card or full Social Security Number of member and recipient signature.
 - b. POA
 - i. Verify that the POA is granting health care decision making ability, not just HIPAA rights that allow record review. Reject POA if health care decisions are not included.
 - 1. Agent or designee name listed and relationship to recipient. POA may have two authorized persons (co-POAs)
 - 2. There can be a primary and secondary POA. The secondary should be recorded and designated as the secondary on the case file.
 - ii. Must have two witnesses unless the document is a durable POA dated prior to 10/1/2011. If unsure because no date exists or there is a question of validity, reach out to AHCA for guidance on requesting an affidavit.
 - iii. Witness signature must be present, dated and notarized.
 - iv. Check HT to see if a DAR is on file.
 - 1. If POA is correct and DAR is on file, the POA will replace the DAR. The DAR will remain if it supplements the POA by indicating an entity's representative name.
 - c. Guardianship



- i. Must have the order date, judge's signature, court seal and clerk declaration. Guardianships whether permanent or temporary, are legal documents and cannot be any document other than one issued by the courts. If it is not a court document, reject the guardianship.
 - ii. Verify the effective date
 - 1. Temporary guardianships expire within 90 days after emergency appointment. They may be extended, but will be effective for only a maximum of 180 days.
 - iii. If a Guardianship is on file and a DAR is received, contact the guardian on file to determine if guardianship has changed. If there is no change, reject the DAR.
 - iv.
 - d. Health Care Surrogate
 - i. Agent or designee name listed and relationship to recipient.
 - ii. Must have two witnesses one which cannot be a spouse or blood relative.
 - iii. Witness signature must be present and dated.
 - iv. Notary signature is not required.
 - v. Health care surrogates are long-standing except indicated otherwise.

4. If Document is Correct

- a. Search for case in HealthTrack using numbers given in the DAR form and enter in the search field.
- b. Click on the three dots beside the case number at the top of the page.

- c. Go to Document
- d. Document Type: Authorized Representative Form (DAR)
- e. Document Location: Browse the document file you created for DAR forms and choose the proper document.
- f. Document Source: Set to Fax, Email or Mail
- g. Page Count: Enter in the number of pages of the document.
- h. Date Received: Change to the correct date the document was received
- i. Document Type: Enter Authorized Representative or Legal Document Form for the type of document.
- j. Authorized Representative First Name(s): Add the correct first name of the Authorized Representative.
- k. Authorized Representative Last Name(s): Add the correct last name of the Authorized Representative.
- l. Person: Select the name of the person on the case that the document is for.



- m. Notes: Add notes describing what type of Document you are adding and anything necessary to the case.
5. **If Document is NOT Correct**
- a. Open the case in HealthTrack.
 - b. Add case notes explaining why the document was incorrect by clicking on three dots beside the case number at the top of the page.
 - c. Close case.
 - d. If case is not found in HealthTrack the DAR form is color-coded and rejected as incomplete in Fax and email inbox.

**DESIGNATION FOR AUTHORIZED REPRESENTATIVE FOR SELECTION OF
MANAGED CARE PLAN****Recipient Information**

Last: _____ First: _____ Middle Initial: _____

Recipient Medicaid ID: _____ Recipient Date of Birth: _____

I wish to designate the person below as my authorized representative for the purpose of selecting my managed care plan with the Agency. I understand some of my protected health information could be discussed in this selection process.

I fully understand that this designation of authorized representation will only permit my Representative to make the health care decision to select my managed care plan.

I also understand that by signing and submitting this form, any previously submitted designated authorized representative form will no longer be valid and cannot be used to select a managed care plan.

Designation will expire in one year or on this date: _____

Representative: _____
(Print Name)

Address: _____

Phone: _____

Government Issued ID Number: _____
(Examples: Driver's License, Passport, Green Card etc...)

Last 5 digits of Social Security #: _____

Providing the Social Security Number is not required. If provided, the Agency will use this information to confirm the identity. Authority given by 42 CFR 435.910.



Recipient:

(Print Name)

(Signature)

Date: _____

Witness:

(Print Name)

(Signature)

Date: _____

Relationship to recipient: _____

Form Instructions

Recipient Information:

Last: Enter the legal last name of the recipient.

First: Enter the legal first name of the recipient.

Middle Initial: Enter the first letter of the legal middle name of the recipient.

Recipient Medicaid ID: Enter the Medicaid ID of the recipient.

Recipient Date of Birth: Enter the date of birth for the recipient.

Representative Information:

Representative: Enter the legal name of the representative.

Address: Enter the mailing address of the representative.

Government Issued ID Number: Enter the Government Issued ID of the representative.

(If the representative does not have a Government Issued ID, then they should move to the next step.)

Last 5 Digits of Social Security#: Enter the last 5 digits of the representatives Social Security Number.

Final Instructions:

The form must be signed and dated by the recipient and a witness and submitted using one of the methods below.



Email	Fax	Mail
fenrollmentrequest@automated-health.com	(850) 402-4678	Agency for Health Care Administration P.O. Box 5197 Tallahassee, FL 32314

I understand: I have the right to cancel this authorization by writing to the Agency. Any information previously disclosed would not be subject to my canceling the request. The information discussed during plan selection could be disclosed by the person I am authorizing and no longer protected. I do not have to sign this authorization. If I do not sign, my ability to obtain treatment, payment for health care services or eligibility for benefits will not be affected.

Prepared By: [REDACTED]

DURABLE POWER OF ATTORNEY

BY THIS DURABLE POWER OF ATTORNEY, I, [REDACTED]
currently residing in Pinellas County, Florida, appoint as my attorney in fact to manage my affairs as indicated below, my sister, [REDACTED] and my niece, [REDACTED]
or the survivor of them, and it is my intention that either of my Agents listed herein can act without the joinder of the other. Reference herein to Agent, Surrogate, Attorney and Attorney-in-Fact shall mean the person named herein to manage my affairs. This durable power of attorney is not affected by my subsequent incapacity except as provided by Florida Statute Section 709, and is exercisable from the date of execution.

1. **General Grant of Power:** I hereby grant to my Agent full power and authority to exercise or perform any act, power, duty, right or obligation whatsoever that I now have or may hereafter acquire, relating to any person, matter, transaction, or any interest in property owned by me, including, without limitation, my interest in all real property, including homestead real property; all personal property, tangible or intangible; all property held in any type of joint tenancy, including a tenancy in common, joint tenancy with right of survivorship, or a tenancy by the entirety; all property over which I hold a general, limited, or special power of appointment; choses in action; and all other contractual or statutory rights or elections, including, but not limited to, any rights or elections in any probate or similar proceeding or any civil cause of action to which I am or may become entitled; all as to such property now owned or hereafter acquired by me. I grant to my Agent full power and authority to do everything necessary in exercising any of the powers herein granted as fully as I might or could do if personally present, with full power of substitution or revocation. Except as otherwise limited by applicable law, or by this durable power of attorney, my attorney in fact has full authority to perform, without prior court approval, every act authorized and specifically enumerated in this durable power of attorney. I hereby ratify and confirm that my Agent shall lawfully have, by virtue of this durable power of attorney, the powers herein granted, including, but not limited to, the following:

a. forgive, request, demand, sue for, recover, collect, receive, and hold all sums of money, debts, dues, commercial paper, checks, drafts, accounts, deposits, legacies, bequests, devises, notes, interests, stock certificates, bonds, dividends, certificates of deposit, annuities, pensions, profit sharing, retirement, social security, insurance, and other contractual benefits and proceeds, intangible and tangible property and property rights and any demands whatsoever, liquidated or not, that I now or hereafter own or that are due, owing or payable or belonging to me or in which I may now have or hereafter acquire.

b. have, use, and take all lawful means and equitable and legal remedies and proceedings in my name for the collection and recovery of any property now or hereafter

RE: Durable Power of Attorney

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owned by me, and adjust, sell, compromise, and agree for the same, and execute and deliver for me, on my behalf and in my name, all endorsements, releases, receipts, or other sufficient discharges for the same.

c. conduct investment transactions as provided in section 709.2208(2), Florida Statutes; and acquire, purchase, invest, reinvest, exchange, grant options to sell, and sell and convey personal property, tangible or intangible, or interests therein, for such price and on such terms and conditions as my agent shall deem proper, including, without limitation, stocks, bonds, warrants, debentures, commodities, precious metals, futures, currencies, and investment funds, including common trust funds, in domestic and foreign markets.

d. execute stock powers or similar documents on my behalf and delegate to a transfer agent or similar person the authority to register any stocks, bonds, or other securities either into or out of my name or my nominee's name and to conduct investment transactions as provided in §709.2208(2), Florida Statutes, sell bonds, shares of stock, warrants, debentures, or other assets belonging to me, and execute all assignments and other instruments necessary or proper for transferring them to the purchaser or purchasers, and give good receipts and discharges for all money payable in respect to them.

e. redeem bonds issued by the United States Government or any of its agencies or any other bonds and any certificates of deposit or other similar assets belonging to me.

f. acquire, purchase, exchange, grant options to sell, and sell and convey any and all of my real estate, lands, tenements, leases, leaseholds or other property in the nature of real estate, or any part or parcel thereof, which I now own or may hereafter acquire, or interests therein, including my homestead real property, at public or private sale, for such price and on such terms and conditions as my agent shall deem proper, and execute any and all documents necessary to effectuate the same, including but not limited to contracts, deeds, affidavits, bills of sale, assignments, and closing statements; provided, however, that if I am married, my agent may not convey or dispose of my homestead property without joinder of a spouse or a spouse's legal guardian. (Joinder by a spouse may be accomplished by the exercise of authority in a durable power of attorney executed by a spouse, and either a spouse or I may appoint the other as attorney-in-fact.)

g. maintain, repair, improve, invest, manage, partition, insure, rent, lease, encumber, and in any manner deal with any real or personal property, tangible or intangible, or any interest therein, that I now own or may hereafter acquire, in my name and for my benefit, upon such terms and conditions that my agent shall deem proper, and execute, acknowledge, and deliver all instruments necessary to effectuate the foregoing.

h. draw, accept, endorse or otherwise deal with any checks or other commercial



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I hereby confirm all acts of my attorney in fact pursuant to this power. Any act that is done under this power between the revocation of this instrument and notice of that revocation to my attorney shall be valid unless the person claiming the benefit of the act had notice of that revocation.

IN WITNESS WHEREOF, I have set my hand and seal on this 21st day of November, 2018.

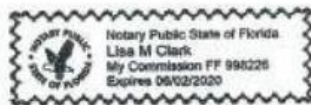
Witness


Witness

STATE OF FLORIDA
COUNTY OF PASCO

BEFORE ME, this 21st of November, 2018, personally appeared [REDACTED] who () is personally known to me or (✓) produced a Florida Drivers License as identification, and who acknowledged before me that he executed the foregoing instrument freely and voluntarily for the purposes therein expressed.

{SEAL}




Lisa M. Clark
Notary Public



IN THE CIRCUIT COURT IN AND
FOR BROWARD COUNTY, FLORIDA

PROBATE DIVISION

FILE NO. [REDACTED]

IN RE: GUARDIANSHIP OF
[REDACTED]

Incapacitated.

PROBATE

14 FEB 12 PM 2:09

FILED FOR RECORD
CLERK, CIRCUIT COURT
BROWARD COUNTY, FL

THIRD AMENDED LETTERS OF GUARDIANSHIP OF THE
PERSON AND PROPERTY NUNC PRO TUNC

TO ALL WHOM IT MAY CONCERN:

WHEREAS, [REDACTED] on February 4, 2003, *nunc pro tunc*, has been appointed Guardian of the person and property of [REDACTED] (the Ward) and has taken the prescribed oath and performed all other acts prerequisite to issuance of Letters of Guardianship of the person and property of the Ward.

NOW, THEREFORE, I the undersigned Circuit Judge, declare [REDACTED] INC. duly qualified under the laws of the State of Florida to act as Guardian of the person and property of [REDACTED] with full power to have care, custody and control of the Ward, to exercise all delegable legal rights and powers of the Ward, to administer the property of the Ward according to law, and to take possession of and to hold, for the benefit of the Ward, all the property of the Ward, and all of the rents, income, issues and profits from it.

ORDERED on FEB 11 2014, 20

CIRCUIT COURT JUDGE

MARK A. SPENCER

Copy furnished to:
[REDACTED]

STATE OF FLORIDA
BROWARD COUNTY
I DO HEREBY CERTIFY the within and foregoing is a true and correct copy of the original as it appears on record and file in the office of the Circuit Court Clerk of Broward County, Florida, and that the same is in full force and effect.
WITNESSED my hand and Official Seal at Fort Lauderdale, Florida, this the 12 day of FEBRUARY, 20 14.
Shirley Charles
Clerk



DESIGNATION OF HEALTH CARE SURROGATE

If I, [REDACTED] am at any time incapable of making health care decisions for myself, and it is determined pursuant to Section 765.204, Florida Statutes, that I lack the capacity to make health care decisions for myself or to provide informed consent, I designate [REDACTED] to serve as my health care surrogate to make all health care decisions for me, subject to the restrictions, if any, set forth herein and the statutory restrictions on a health care surrogate's powers, until such time as I regain the capacity to make such decisions or provide informed consent myself. I designate my health care surrogate as my personal representative under 45 CFR § 164.502(g), a portion of the regulations implementing the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), for all health care-related decisions. If [REDACTED] to serve as my health care surrogate. By way of example and not in limitation, my health care surrogate may:

- act for me and to make all health care decisions for me in matters during my incapacity, as my surrogate deems to be in my best interest, and to execute on my behalf any documents necessary to implement such health care decisions, including the ability to enter into personal services contracts, lump sum or periodically, with my caregivers for my benefit;
- consult expeditiously with any health care providers to provide informed consent in my best interest, and to make health care decisions which my surrogate believes I would have made under the circumstances if I were capable of making such decisions;
- provide written consent using an appropriate form provided by any health care provider, including a physician's order not to resuscitate;
- request, receive and review any information concerning my mental and physical health, including but not limited to medical and hospital records and other protected health information as defined by HIPAA;
- apply for public and veterans' benefits, such as Medicare and Medicaid, for me and to have access to information regarding my income and assets and banking and financial records to the extent required to make application;
- authorize the release, use and disclosure of records including the protected health information described above to appropriate persons as necessary to ensure the continuity of my health care;
- authorize my admission to or transfer from a licensed health care facility; and
- carry out the terms of any living will or declaration made by me.

LIVING WILL DECLARATION

I, [REDACTED] willfully and voluntarily make this declaration on July 23, 2018. I recognize that death is natural and is but a phase in the cycle of life. I do not fear death as much as I fear the indignity and futility of deterioration, dependence, and hopeless pain. If there is no reasonable medical expectation of my recovery from a physical or mental disability, I do not wish to be kept alive by artificial means or heroic measures.

Therefore, if my attending or treating physician and another consulting physician determine that there is no reasonable medical probability of my recovery from any of the following conditions, I direct that life-prolonging procedures be withheld or withdrawn when the application of those procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain, even if that hastens my death:

- I have a terminal condition caused by injury, disease, or illness from which there is no reasonable medical probability of recovery and which can be expected to cause my death if not treated.
- I am in an irreversible end-stage condition that is caused by injury, disease, or illness that has resulted in severe and permanent deterioration, indicated by my incapacity and complete physical dependency, for which treatment would be medically ineffective to a reasonable degree of medical certainty.
- I am in a persistent vegetative state characterized by permanent and irreversible unconsciousness in which there is an absence of voluntary action or cognitive behavior of any kind by me, with an inability to communicate or interact purposefully with others in the environment around me.

In any of the situations described above, I direct that the following medical interventions that I have initialed be considered life-prolonging procedures, and therefore not applied or continued.

- Placement or continuance on a ventilator or other mechanical devices, including internally implanted devices, or dialysis treatment
- Surgical procedures and blood transfusion, except as needed to prevent or alleviate suffering
- Placement in an intensive care unit except as an absolute necessity to relieve suffering
- Chemotherapy or radiation therapy, unless there is a substantial medical probability my condition will materially improve
- Resuscitation efforts in the event of arrest of my heart or breathing
- Active treatment of a new reversible condition such as newly-discovered cancer, heart attack, or pneumonia
- Artificial nutrition and hydration (providing food and water through tubes)

SENIOR COUNSEL, ATTORNEYS AT LAW, P.A.
2318 PARK STREET, JACKSONVILLE, FLORIDA 32204



I request as much as possible treatment at home or in a comfortable bed in home-like, comfortable surroundings.

On my death, and at no cost to my estate:

_____ I give any needed organs or parts of my body, if medically acceptable, for the purposes of transplantation, therapy, or medical research and education.

_____ I give any needed organs or parts of my body, if medically acceptable, for the purposes of transplantation only.

_____ I do not wish to be an organ donor.

I intend that this declaration be honored by my family and my physicians as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal. I understand that my wishes may place a heavy burden upon others, and so I make this declaration to assume sole responsibility for my decision and to mitigate any feelings of guilt that my wishes may cause. A duplicate or photocopy of this instrument shall have the same force and effect as the original.

I am emotionally and mentally competent to make this declaration, and I understand its importance.

Signed on this 23 day of July, 2018.

Print Name: _____

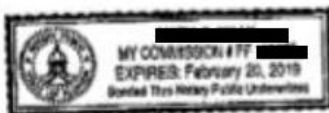
Signature affixed by notary pursuant to s.117.05(14), Florida Statutes

Print Name: _____

Two witnesses as to _____

STATE OF FLORIDA
COUNTY OF DUVAL

The foregoing instrument was acknowledged before me this 23 day of July, 2018, by _____ and subscribed by _____ at the direction of and in the presence of _____ and _____ and in the presence of these witnesses: _____ and _____, who are personally known.



Notary Public--State of Florida