ES-3108
05-08

Instructions: The child's parent or legal guardian must complete this form entirely. This appointment is only valid for one child. If the parent or legal guardian wants to appoint an authorized agent for more than one child, a completed form for each individual child is required. This form must be signed and notarized to be valid. Copies of the adult's legal guardianship papers are required, if someone other than the child's biological or adoptive parent is making the appointment. If you have questions about completing this form contact the HealthWave Eligibility Clearinghouse at 1-800-792-4884.

Appointment of Authorized Medical Agent for a Minor

I, _____, certify
(Full Name of Parent or Legal Guardian)
I am the parent (biological or adoptive) or legal guardian of the following child.

_____	_____	_____
Child's Full Name (First, Middle Initial, and Last)	Date of Birth	Social Security Number

The child listed above does not live with me at this time. My child is not living with me because _____

_____

_____

_____

_____

_____.

I hereby appoint _____, an adult
(Full Name of Adult Caring for the Child)
with whom my child is residing and who is exercising care and control over my child, to act in my child's behalf.

- I understand that I name this agent to be my child's representative to apply, maintain, and manage my child's medical assistance case with the Kansas Department of Health and Environment (Kdhe) and the Department for Children and Families (DCF).

- I understand making this appointment allows this agent to receive any and all communications from DCF and Kdhe about my child's medical eligibility and coverage including Protected Health Information. This information may include written, electronic or oral information related to eligibility, claims for benefits, and payment of benefits. I understand that after this information is disclosed, federal

law might not protect it and the recipient might disclose it again. I understand that I have a right to receive a copy of this authorization.

- I understand naming this agent is temporary and only lasts for 15 months.
- I understand that KDHE or DCF will review my child's medical case regularly and will ask for a new appointment form.
- I understand I may revoke this appointment at any time and that I may have a copy of this appointment form upon request.
- I understand that this authorization does not pertain to accessing medical care from a medical facility. A medical facility may require that I sign additional releases to authorize the above named adult to obtain medical care for the child.

Print Parent or Legal Guardian's Name: _____

Parent or Legal Guardian's Address: _____

_____

_____

Parent or Legal Guardian's Telephone
(or Message) Number: _____

_____ _____
Parent or Legal Guardian's Signature Date

Notarization of Parent or Legal Guardian's Signature is Required.

State of _____
County of _____

Signed before me on _____
MM/DD/YYYY

_____
Signature of Notary Officer

My appointment expires: _____