# Authorized Representative Form

DC HEALTH LINK
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Form Approved
OMB No. 0938-1191

## Assistance with completing this application

**You can choose an authorized representative.**
You can give a trusted person permission to talk about this application with us, see your information, and act for you on matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative." If you ever need to change your authorized representative, contact DC Health Link. If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First name, Middle name, Last name)

2. Address

3. Apartment or suite number

4. City

5. State

6. ZIP code

7. Phone number

( ) –

8. Organization name

9. ID number (if applicable)

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters related to this application.

10. Your signature

11. Date (mm/dd/yyyy)

/ /

**For certified application counselors, navigators, agents, and brokers only.**
Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)

/ /

2. First name, Middle name, Last name, & Suffix

3. Organization name

4. ID number (if applicable)

5. Agents/Brokers only: NPN number

**NEED HELP WITH YOUR APPLICATION?** Visit DCHealthLink.com or call us at **1-855-532-5465**. Para obtener una copia de este formulario en Español, llame **1-855-532-5465**. If you need help in a language other than English, call **1-855-532-5465** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **711**.