8630 Government Dr., Suite 103
New Port Richey, FL 34654
Ph.: (727) 841-0202 Fax: (727) 478-0286 Website: www.crsmbc.net

I, _____, hereby designate CRS Medical Benefits, Inc. as my representative to act on my behalf, or assist in the application process and/or appeal of my application for medical assistance programs (Medicaid, AFDC, SSI related Medicaid, etc.) and/or Food Stamps. I authorize CRS to file application/s, either hard copy or online by computer, which includes authorization for electronic signature. In addition to the above, my signature specifically authorizes the following:

Allow Dept. of Children & Family Services to release and & all information regarding the status; disposition; eligibility; denial; appeal of my application for medical or public assistance; Access to the information filed via the Platinum Community partner website. This includes, but is not limited to: appointment information; any information regarding eligibility or denial reason/s; share of cost; pending status/reasons, etc.

Allow for CRS representation and/or assistance at a Fair Hearing Appeal filed against Dept. of Children & Family Services due to denial or reduction of benefits or the lack of decision in a timely manner;

Allow Social Security Administration to release any and all information pertaining to my application for benefits administered by their department. This includes but is not limited to: information regarding status; approval; denials; reasons for denials; appeal information; effective dates; award benefits; medical information that would relate to same;

Receipt of income verification (TPQY), Social Security Number Verification (NUMI), or other information pertaining to the Social Security Administration;

I hereby grant permission and authorize any bank, building association; employer, insurance company or other financial institution of any kind or character to disclose full information as to my past and/or current bank accounts, earnings, insurance policies, or property;

All medical records or other information regarding my treatment, hospitalization, and/or outpatient care for my conditions, including psychological, or psychiatric impairment, drug abuse and/or alcoholism, sickle cell anemia, Acquired Immunodeficiency Syndrome (AIDS), test for or infection with Human Immunodeficiency Virus (HIV) regarding my treatment and/or hospitalization, which CRS has my permission to release as it pertains to my application for benefit/s, including Medicaid, AFDC, Social Security, SSI or related Medicaid programs; or related program/s;

Information about how my impairment affects my ability to work, complete tasks and daily activities of daily living;

I hereby grant permission for a CRS representative to obtain a certified copy of a birth or death certificate with cause of death listed for myself or a member of my immediate family. This is being done in order to initiate or continue the application process for disability or medical benefits;

I hereby grant permission for a CRS representative to contact, give and/or receive information from any attorney or disability specialist that may represent me in obtaining disability benefits through Social Security and/or Medicaid benefits/disability;

Signed: _____ Date: _____ Social Security #: _____-_____-_____