Advocates & Guardians for the Elderly & Disabled, Inc.

1607 Cherrywood Lane
Longwood, FL 32750
Phone: 407-682-4111
Fax: 407-682-5511
www.trustaged.org

DCF Community Partner Release

I, _____ understand that by my signature I am authorizing
Medicaid Applicant
the Department of Children and Families (DCF) to release limited case information to **AGED, Inc**. and its representative in their role as a DCF Community Partner. Information shall be used solely to fulfill their obligation in assisting me with filing an application or an application previously filed with DCF.

I further consent to allow AGED to share information related to the trust account to other agencies/entities in connection with establishing eligibility of Medicaid benefits.

Information to be released is limited to:

- Status of application (approved, denied, enrolled or pending)
- Reason for closure or denial
- Scheduled interview dates and times
- Verification requested and dates due
- Other: _____

No additional information shall be provided to the Community Partner without my specific written consent. This authorization expires one year following the disposition of the above-mentioned application.

DISCLAIMER: AGED cannot provide you with any legal advice concerning Medicaid planning. Moreover, AGED cannot make any assurances or guarantees as to whether your Medicaid application will be approved, denied, or reviewed in a timely manner by the Department of Children and Families.

DCF Community Partner Release

HIPAA RELEASE PROVISION: By signing this form, a Trust Beneficiary (or by and through his or her Beneficiary Advocate or Legal Representative) authorizes the release of all individually identifiable health information and medical records pertaining to the Trust Beneficiary received by AGED, the Trustee, and their designated employees and agents to the Department of Children and Families and shall be used solely to fulfill their obligation in assisting with the Medicaid application process. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. I 320d and 45 C.F.R. 160-164 and to all entities and individuals covered by HIPAA. This authority expires one year following the disposition of the above-mentioned application.

Signature: _____ Date: _____
Medicaid Applicant or Legal Representative

Date of Birth: _____ Last 4 digits of SSN: _____
Medicaid Applicant Medicaid Applicant