Personal Representative Authorization Form Instructions

About this form
You may submit this Personal Representative Authorization (PRA) Form if you would like to designate someone to act on your behalf in all matters related to Fallon Heath.

Note: A Personal Representative designated through this form has the authority to act on your behalf in all matters with Fallon Health, and will receive personal medical and financial information about you until we receive a cancellation notice terminating their authority, or until the death of the member. If you are filling this out prior to becoming a member, their authority will not automatically terminate once we process your application.

Who can help me?

1. A Personal Representative can be a friend, family member, relative, or other person or organization of your choosing who agrees to help you. It is up to you to choose a Personal Representative if you want one. Fallon Health will NOT choose a Personal Representative for you. To select a Personal Representative:
   a. You must designate the person or organization in writing, by filling out Part A of this form, who you want to be your Personal Representative.
   b. Your Personal Representative must also fill out Part B.
   c. You must fill out a separate PRA form if you want to name more than one person to serve as Personal Representative.

2. A person appointed by law to act on behalf of an applicant or member can also serve as a Personal Representative by following the instructions above. This type of Personal Representative may be a legal guardian authorized to make medical decisions, holder of a durable power of attorney, or health care proxy, or, if the applicant or member has died, the estate's administrator or executor. What this person is authorized to do for you or for the applicant's or member's estate will depend on the wording of the legal appointment.

What can a Personal Representative do?

A Personal Representative may:

- Fill out your application or eligibility review forms
- Fill out other Fallon Health eligibility or enrollment forms
- Give proof of information reported on these forms
- Report changes in income, address, or other circumstances
- Get copies of all of your Fallon Health eligibility and enrollment notices
- Act on your behalf in all other matters with Fallon Health including filing an appeal, a grievance or a request for service

How does a Personal Representative designation end?

If you decide that you no longer want a Personal Representative, you must notify us that you want the designation to end in one of the following ways:

Mail: Fallon Health
Privacy Coordinator
10 Chestnut St.
Worcester, MA 01608

Fax: 1-508-831-1136

Email: E&BPrivacyCoordinator@fallonhealth.org

The notice must include:

- Your name
- Your address
- Date of birth
- The name of your Personal Representative
- A statement that the designation has ended
- Your signature or the signature of someone acting on your behalf

Otherwise, your Personal Representative's designation as such will end upon your death. In addition, if your Personal Representative notifies us that they are no longer acting on your behalf, we will no longer recognize that person or organization as your Personal Representative.

Please note: A Personal Representative's designation for a minor child ends on the date the child turns 18.

How do I submit this form?

You must **return all pages of this form** in one of the following ways:

Mail: Fallon Health
Privacy Coordinator
10 Chestnut St.
Worcester, MA 01608

Fax: 1-508-831-1136

Email: E&BPrivacyCoordinator@fallonhealth.org

Personal Representative Authorization Form

Part A—You fill out this section. Please print, except for signature.

Member/Applicant Information:

First name:	Middle initial:	Last name:	
Street address:	City:	State:	ZIP code:
Date of birth:	Phone number:	Fallon member ID number:	

I certify that I have chosen the following person or organization to be the Personal Representative for myself and any dependent children under the age of 18 for whom I am the custodial parent and that I understand the duties and responsibilities this person or organization will have (as explained earlier in this form). I understand that when the person or organization named below gets this information from Fallon Health, that person or organization may be able to share it with others without my permission. If they do so, federal and state privacy laws may not protect the information.

_______________________________________ _______________________________

Signature of member or applicant Date

Personal Representative Information:

First name:	Middle initial:	Last name:	
Name of Organization *(if applicable):*			
Street address:	City:	State:	ZIP Code:
Phone number:	Email address:		

Part B—Your Personal Representative fills out this section. Please print, except for signature.

B1: If you are an individual, please complete the section below.
I certify that I will at all times maintain the confidentiality of any information regarding the applicant or member set forth on the previous page and, if applicable, the dependent children of such applicant or member, that is provided to me by Fallon Health.

If I am also a provider, staff member, or volunteer affiliated with an organization, and I am acting in my own capacity, and not on behalf of any organization, in connection with my designation as a Personal Representative, I certify that I will at all times adhere to all applicable state and federal laws and regulations regarding confidentiality of information and conflicts of interest including those set forth at 201 CMR 17.00, 42 C.F.R. part 431, subpart F, 42 C.F.R. § 447.10, 45 C.F.R. § 155.260(f) and 45 CFR Part 164.

______________________________	______________________________
Signature of Personal Representative	Date

____
Personal Representative's printed name

B2: If you are an organization, please complete the section below.
I certify, on behalf of the organization set forth below, that such organization will at all times maintain the confidentiality of any information regarding the applicant or member set forth above and, if applicable, the dependent children of such applicant or member, that is provided to the organization by Fallon Health.

I, the provider, staff member, or volunteer of the organization set forth below, completing this form, certify on behalf of myself and on behalf of the organization I represent, that any providers, staff members, or volunteers acting on behalf of the organization in connection with this Personal Representative designation will at all times adhere to all applicable state and federal laws and regulations regarding confidentiality of information, and conflicts of interest, including those set forth at 201 CMR 17.00, 42 C.F.R. part 431, subpart F, 42 C.F.R. § 447.10, and 45 C.F.R. § 155.260(f) and 45 CFR Part 164.

______________________________	______________________________
Signature of provider, staff member or volunteer completing the form	Date
Printed name of person completing the form	Organization name

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