DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-10080 (07/08)

STATE OF WISCONSIN
Section 49.688, Wis. Statutes

SENIORCARE AUTHORIZATION OF REPRESENTATIVE

This form must be completed by the person who has completed the SeniorCare application on behalf of an applicant. Social Security Numbers and personally identifiable information will only be used for the direct administration of the SeniorCare Program.

Did you complete a SeniorCare application on behalf of another person and are you that person's court appointed guardian or have durable power of attorney for finances for that person? ☐ Yes ☐ No

If you answered "Yes", stop here. You must submit the legal documentation authorizing you to be that person's appointed guardian or durable power of attorney for finances to the SeniorCare program at the address listed on the bottom of this form.

Are you an authorized representative who has completed the SeniorCare application for another person? ☐ Yes ☐ No
If you are an Authorized Representative, then you and the applicant must complete the information below, sign this form and the Rights and Responsibilities Section of the SeniorCare application. Signing this form authorizes you to be an authorized representative. This completed form must be returned to the SeniorCare program at the address below.

Name – Applicant	Social Security Number - Applicant
Name - Authorized Representative (Last, First, MI)	Telephone Number ( )
Address (Street, City, State, Zip Code)	E-mail Address (Optional)

I authorize _____(name of representative) to represent me in my application for SeniorCare and for reviews of my SeniorCare eligibility. I also authorize my representative to provide information and documents which may be necessary to establish my eligibility for SeniorCare. I will provide information to my representative that will be true and correct to the best of my knowledge. My representative and I understand that penalties for providing fraudulent information could be a fine of not more than $10,000 or imprisonment of not more than one year, or both. (NOTE: Someone must witness your signature other than your representative. Two witness signatures are required if you sign with an "X".)

SIGNATURE – Applicant	Date Signed
SIGNATURE – Witness	Date Signed
SIGNATURE - Witness	Date Signed

As an authorized representative I understand that I am representing the above named applicant for SeniorCare eligibility and that information provided is true and correct to the best of my knowledge. Good faith estimates will not be penalized as long as there is no intent to provide misleading, fraudulent, omitted or incomplete information.

SIGNATURE – Authorized Representative	Date Signed

Return form and necessary documentation to:

SeniorCare
P.O. Box 6710
Madison, WI 53716-0710

RESET FORM