AUTHORIZATION TO DISCLOSE INFORMATION TO DELAWARE HEALTH AND SOCIAL SERVICES
DIVISION OF MEDICAID & MEDICAL ASSISTANCE

Name of Person Whose Records Are to be Disclosed:	
Date of Birth (MM/DD/YYYY):	Social Security Number:

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange) of the information listed below to Delaware Health and Social Services and/or its Managed Care representatives: Highmark and United Healthcare Community Plan of Delaware, for determining my eligibility for medical assistance and/or food benefits. This release may be used to ask for, receive and/or release information that is pertinent to my eligibility determination.

All my medical records:

1. All records and other information regarding treatment, hospitalizations, and outpatient care for my impairment(s).
2. Information about how my impairment(s) affect my ability to complete tasks, activities of daily living, and specific functions in the work environment.

All Financial records:

1. All records from financial institutions, including information of any accounts closed within the last 60 months.
2. Information from all sources of income (Social Security Administration, current and past employers, Annuity companies, etc).
3. All life insurance companies.

Awareness Statement:

I understand that I have the choice of either Long Term Care Community Services or Residential Placement.

I choose to apply for (**check only one**):

- ○ Assisted Living
- ○ Long Term Care Community Services
- ○ Nursing Facility
- ○ PACE

This authorization ends when the information asked for is received, or 12 months from the date signed or until revoked by me in writing, whichever comes first.

Signature of Individual Authorizing Disclosure:			
If not signed by subject of disclosure, specify basis for authority to sign (provide supporting documentation): ☐ Parent of Minor ☐ Power of Attorney ☐ Guardian ☐ Other			
Date Signed	Address		
Telephone Number:	City	State	Zip Code