Northeast Behavioral Health Partnership, LLC 1300 N. 17th Ave. Greeley, CO 80631
phone 970-347-2622 fax 970-392-1354 toll free 1-888-296-5827

Authorization for Designated Client Representative (DCR)

Read this information first: You should fill out this form if you want to name another person to act on your behalf to file a grievance or an appeal. This person will be your *Designated Client Representative (DCR)*. By signing this form, you allow Northeast Behavioral Health Partnership (NBHP) to share information with your DCR. NBHP will only share information about your grievance or appeal. This consent will stay in effect until (a) the date you specify (cannot be more than one year); (b) one (1) year from the date signed; or (c) the date you cancel your consent.

After completing this form, follow the instructions of the person who gave you this form, or send it to NBHP (address above).

Step 1: Tell us about yourself (or the person receiving services, if a minor). This will help us find that person's records:

1. _____ 2. __ __ / __ __ / __ __ __ __
Name Date of Birth

3. _____ 4. (__ __ __) __ __ __ - __ __ __ __
Address Phone Number

Step 2: Tell us whether the person you name as a DCR will be helping you with a grievance or an appeal:

5. Check a box: ☐ DCR for an Appeal ☐ DCR for a Grievance

Step 3: Tell us who you are naming to act as your Designated Client Representative (DCR). You can ask anyone to act on your behalf.

6. _____ _____
Name of DCR Address/Telephone of DCR

7. Relationship to DCR_____

8. **OPTIONAL:** Date you would like this approval to end: __ __ / __ __ / __ __ __ __ /

Step 4: In completing this form, you understand that:

- You do not have to fill out this form. You will still get all of your Medicaid benefits if you don't want to fill out this form.
- If you sign this form, NBHP does not have control over how your DCR uses your information. If your DCR discloses private information about you, you may no longer be protected by federal privacy laws.
- You can cancel this authorization at any time by filling out Step 5: "Cancellation of Authorization" below. After you have filled it out and signed it, send it to NBHP. You can also call NBHP to ask for a cancellation at 1-888-296-5827.
- You have a right to get a paper or other copy of this signed approval.

9. _____ _____
Signature of person receiving services Date
(Note: Minor children age 15 or older must sign the release for themselves. Parents cannot sign for children over age 15.)

10. _____ _____
Signature of Parent and/or Guardian (if applicable) Date

11. _____ _____
Witness Signature Date

Step 5: Cancellation of Authorization: If you do not want the person in Step 3 to continue to as act as your Designated Client Representative, you may cancel your permission for them to do so. This section needs to be completed and sent to Northeast Behavioral Health Partnership.

I hereby cancel my consent for this Authorization for Designated Client Representative.

_____ _____
Consumer Signature Date Witness Signature Date