Responsible Party/Patient			Social Security Number	
Address			Home Phone	Relative Phone
City	State	Zip	Hospital / Admit-Date	

PATIENT
AUTHORIZATION TO REPRESENT (ATR)

(Waiver of Information)

I HEREBY designate and appoint any Employee, Agent, or Authorized Representative of HEALTHCARE RESOLUTION SERVICES, INC. to represent me and act on my behalf before any County or State Department of Jobs and Family Services, the Court of Claims of Ohio, the Social Security Administration and/or Veterans Administration or any other Medical Institution.

I HEREBY grant to my Representative the power to make or withdraw application on my behalf, and to request and appear on my behalf at conferences, hearings and other proceedings that pertain to applications for assistance made for me, or other members of my family.

I UNDERSTAND that all information furnished will be used only for assistance in obtaining the full amount available of Government Benefits that I may be entitled to.

I CONSENT to the disclosure and release to my Representative, all hospital records, case records, medical and psychiatric reports (including, if necessary, reports relating to drug, alcohol, and HIV Positive/AIDS information) and/or documents that pertain to me or my family and are in the custody of these agencies.

I UNDERSTAND that this Representation is being used to obtain Government Benefits and is being done at NO COST to me or my family.

THIS AUTHORIZATION will remain in effect until I request to withdraw it in writing.
A photocopy of this document shall be valid as the original.

Signature	**Witnessed**	**Date**

3250 West Market Street, Suite 304 Akron, Ohio 44333
330-864-5000-Call 800-247-3328-TollFree 330-864-3344-Fax

MEDICAL COVERAGE SCREENING

Directions: Please complete questions #1-10 below to help us determine your eligibility for medical coverage. Your timely assistance with this information will allow us to process your account faster!

1. Do you have health insurance? ☐ Yes ☐ No If yes, return a copy of the card in the enclosed envelope.

   Name of Insurance:______________________________

   (please include PPO, HMO, Select, etc.)

   ID #: ______________________________

   Group Name: ______________________ Group #: ______________________

   Subscriber Name: ______________________ Date of Birth: __________ Social Security #: __________

   Your relationship to Subscriber:______________________________

   When did coverage begin: ______________________________

   (Back of Card) Insurance Mailing Address: ______________________________

   ____

   Insurance Phone # (Provider): _ ______________________________

2. Are you working? ☐ Yes ☐ No If yes, what is your gross income (before taxes) for:

   Month of service?______________ 3 months prior?______________ 12 months prior?______________

   If no, how long unemployed?______________ How supporting oneself? ______________

3. Are you on SSI or SSD? ☐ Yes ☐ No

4. Have you applied for SSI or SSD? ☐ Yes ☐ No If yes when ______/______/__________

   Status of SSI or SSD claim ______Pending ______Denied ______Appealing

5. Do you feel you are unemployable for 12 or more months? ☐ Yes ☐ No

   If yes, what is your disability?______________________________

   How does this disability affect your ability to work?______________________________

   Does your doctor think you are disabled? ☐ Yes ☐ No

   Doctor's Name______________________ Doctor's Phone Number______________________

6. Do you have children under the age of 18 in your custody? ☐ Yes ☐ No

7. Are you pregnant? ☐ Yes ☐ No 8. Marital Status? ☐ Single ☐ Divorced ☐ Married ☐ Seperated ☐ Widowed

   List family members in your household: (Family members include spouse, and minor children in your custody. If patient is a minor, family members include parent(s) and any minor siblings.)

NAME	RELATIONSHIP	DATE OF BIRTH

9. Please indicate a phone number where you can be contacted.______________________________

10. Please verify the best address to mail you information: ______________________________

    ____