Reset Form

FSSA LEGISLATIVE INQUIRY: AUTHORIZATION TO ACT ON CONSTITUENT'S BEHALF

State Form 54530 (R / 3-14)

Purpose

The Family and Social Services Administration (FSSA) is Indiana's parent organization for many health and family services. You are requesting that your Indiana state legislator make an inquiry on your behalf to the appropriate FSSA Program Area(s). This form provides a means for you to identify yourself and describe your concern so that FSSA may act on your concern as quickly as possible. If you want FSSA to provide your state legislator, including their staff, with the details of FSSA's response to your concern, you may authorize FSSA to do so under the Disclosure Authorization section of this form.

Your Information

Name_____ Date of Birth _____

Address_____

City_____ State_____ ZIP Code_____

Telephone (_____)_____ E-mail Address_____

Last 4 Digits of Social Security #_____ RID # for Medicaid Applicants/Beneficiaries_____

The Name of Your State Legislator_____

Personal Representative Information

Name_____

Address_____

City_____ State_____ ZIP Code_____

Telephone (_____)_____ E-mail Address_____

Relationship to the Individual_____

If you are a Personal Representative making an inquiry on someone else's behalf, please provide your contact information above.

Please describe your concern. Attach additional pages as necessary.

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To which FSSA Program Area should your inquiry be directed? *(For example, Indiana Medicaid, Division of Family Resources, Division of Aging, Hoosier Healthwise, Division of Disability & Rehabilitative Services, Division of Mental Health & Addiction, etc. If unsure, specify FSSA.)*

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Disclosure Authorization

The details of FSSA's response to your concern may include certain confidential and personal information, including health information, about you; this information is protected by state and federal privacy laws.

If you want the FSSA Program Area(s) involved with addressing your concern to respond back to your state legislator with these types of details, FSSA needs your written permission to do so and you need to complete this section of the form and sign below. **You are not required to give your written permission, it is entirely optional.**

Whether or not you give this written permission your state legislator will still make the inquiry on your behalf and FSSA will still address your concern as quickly as possible. If you do not give this written permission, FSSA will address your concern and share the details with you, but not with your state legislator.

Expiration Date or Event

This authorization will automatically expire sixty (60) calendar days from the date you sign it. You may specify an earlier or later expiration date, or you may specify an event upon which this authorization will expire (e.g., "when my concern has been addressed"). Please select one of the following three:

❑ Allow to automatically expire in sixty (60) calendar days

❑ Expire on this date (month, day and year): _____

❑ Expire on this event: _____

Right to Revoke

You have the right to revoke this authorization at any time by giving written notice, including e-mail notice, to the Contact below. Please understand that any disclosures of your personal information, including health information, which may have been made under this authorization prior to its revocation will not be affected (they were made while this authorization was still in effect).

Further Disclosure

Once your personal information, including health information, is disclosed to the above state legislator (including their staff), the information may no longer be protected under state or federal privacy laws, and the information may be subject to further use or disclosure.

Signature

Having had full opportunity to read and consider the contents of this authorization, including my rights and the risks of further disclosure as described above, I am authorizing FSSA to disclose my personal information, including health information, to the state legislator (including their staff) named above. I understand the applicable FSSA Program Area(s) will disclose only that information which is necessary to address my stated concern—the information disclosed will be limited to the minimum necessary. I also understand that I am under no obligation to sign this authorization. I understand that the services and benefits that may be provided to me by or through FSSA will not be affected whether or not I sign this form.

Signature_____ Date_____

Personal Representatives must sign on behalf of the individual; it is FSSA's policy to verify that an individual's personal representative is identified as such in our files prior to acting on this authorization.

You will be provided with a copy of this authorization after you sign it.

Contact Information

If you have questions about this authorization or wish to revoke it prior to the above expiration date or event, please contact:

FSSA Office of Communications and Media
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Legislative.Inquiries@fssa.IN.gov • (317) 233-4454