MARYLAND MEDICAL ASSISTANCE PROGRAM

APPLICANT'S AUTHORIZATION – APPOINTMENT OF AUTHORIZED ASSISTANT

I, _____, hereby authorize (choose one):
NAME OF APPLICANT (PRINT)

☐ the person named in Part B below, individually and exclusively

OR

☐ the employees and agents of the entity or organization ("organization") named in Part C below

to act as an **Authorized Assistant** in conjunction with my application for Medicaid Long Term Care.

I empower my Authorized Assistant to perform the following actions:

(a) Prepare and transmit an application, renewal form, or other supporting or supplemental information on my behalf, based on information I provide;

(b) Transmit my signature or that of my authorized representative to complete submission of an application or renewal form;

(c) Access information from and communicate information to the Maryland Department of Health (MDH), the Maryland Department of Human Services (DHS), or other delegated entities regarding the status of my Medicaid case, application, or reauthorization as necessary to assist me with those matters; and

(d) Receive copies of notices sent to me by MDH, DHS, or delegated entities.

The Authorized Assistant is **not authorized to sign** an application on my behalf.

I will provide the Authorized Assistant with accurate and complete information as necessary to perform the actions listed above. My Authorized Assistant has no responsibility to independently verify the accuracy or completeness of the information I provide, except that the Authorized Assistant shall exercise ordinary prudence in the discharge of the actions listed above.

This authorization shall remain in effect while I am living and able and until I notify DHS and MDH that I wish to end this representation.

– PLEASE SIGN FORM ON NEXT PAGE TO COMPLETE –

AUTHORIZING SIGNATURES

Part A – Applicant
(Complete *either* (1) or (2) below)

(1)

APPLICANT'S SIGNATURE — DATE

APPLICANT'S NAME (PRINT)

(2)

SIGNATURE OF APPLICANT'S AUTHORIZED REPRESENTATIVE — DATE

NAME OF APPLICANT'S AUTHORIZED REPRESENTATIVE (PRINT)

(Complete *either* Part B or Part C, depending on type of authorization)

Part B – Authorized Assistant – Individual Exclusive

I hereby acknowledge and accept that I have been authorized and empowered to serve as the Authorized Assistant for the individual identified in Part A, subject to the terms and conditions of this appointment set forth herein.

AUTHORIZED ASSISTANT'S SIGNATURE — DATE

AUTHORIZED ASSISTANT'S NAME (PRINT)

AUTHORIZED ASSISTANT'S ORGANIZATION

Part C – Authorized Assistant – Organization's Employees or Agents (non-Exclusive)

I hereby acknowledge and accept on behalf of the organization listed below that the employees and agents of this organization have been authorized and empowered to serve as the Authorized Assistant for the individual identified in Part A, subject to the terms and conditions of this appointment set forth herein.

AUTHORIZED ENTITY OR ORGANIZATION NAME — ORG ID NUMBER

ORGANIZATION REPRESENTATIVE'S SIGNATURE — DATE

ORGANIZATION REPRESENTATIVE'S NAME (PRINT)