PLAN LOGO

AUTHORIZED REPRESENTATIVE FORM

I, hereby authorize <<*insert SSC Rep name*>> of Social Service Coordinators, Inc. (a contractor of [Medicare Advantage Plan]), to:

- Gather information from me and on my behalf needed to complete and submit a Medical Assistance application to secure and maintain my enrollment in a Medicare Savings Program and/or other Public Assistance Programs, including Extra Help with Part D benefits;
- Contact private and public agencies and businesses on my behalf in order to secure information required by the [State Medicaid Eligibility Authority] and/or the Social Security Administration;
- Disclose my personal information for the sole purpose of submitting and following up on an application or recertification of benefits; and
- Receive a copy of decision notices from the [State Medicaid Eligibility Authority] regarding my application (or redetermination) of Medical Assistance benefits; and
- Discuss the status of my case with case workers.

My Authorized Representative may not sign any public assistance application(s) or make enrollment decisions on my behalf.

This authorization does not extend to representing me before the [State Medicaid Eligibility Authority] and/or the Social Security Administration in any appeal that may be required.

I understand that neither SSC nor [Medicare Advantage Plan] is responsible for the accuracy of information that I provide or is provided on my behalf to SSC to complete applications for Medicare Savings Programs or other Public Assistance Programs on my behalf, including Extra Help with Part D benefits.

I agree to hold [Medicare Advantage Plan] harmless from any claims, liability, judgments, damages, or costs, incurred by [Medicare Advantage Plan] as a result of any inaccurate information provided to SSC.

This authorization shall remain in effect until revoked or replaced by me or my Representative or until SSC is no longer contracted with [Medicare Advantage Plan].

_____ _____

Member's Signature Date