Submission of Application on Behalf of Applicant

COMPLETE THIS FORM IF SOMEONE OTHER THAN THE APPLICANT SIGNED THE MEDICAID APPLICATION

If you are signing a Medicaid application on behalf of an applicant who is age 18 or older, complete **Sections A** through **C** and submit this form along with proof of authorization (if applicable). **Failure to submit this form and/or proof of authorization may result in a denial or discontinuance of Medicaid benefits.**

The authorization in **Section D** may be used by the applicant to allow you to apply for Medicaid on his/her behalf.

SECTION A APPLICANT INFORMATION

Applicant's Name — Last Name | First Name | Middle Initial

Social Security Number ___ – ___ – ____ Date of Birth ___ – ___ – ____

SECTION B INFORMATION FOR PERSON SIGNING APPLICATION ON APPLICANT'S BEHALF

Name of Person Signing Application — Last Name | First Name

Relationship to Applicant _____ Phone ___ – ___ – ____

Address — Number | Street | Apt. Number

City | State | Zip Code

If a representative of a facility/company/agency is signing application, provide the following information:

Name of Facility/Company/Agency _____

Address — Number | Street | Suite Number

City | State | Zip Code

Name of Representative — Last Name | First Name

Title _____ Phone ___ – ___ – ____

SECTION C REASON FOR SUBMISSION

INSTRUCTIONS: If you are signing a Medicaid application on behalf of the applicant, you must provide the authorization/legal document authorizing you to apply on the applicant's behalf **OR** attest that the applicant is incompetent or incapacitated. **Please check the appropriate boxes below. Attach the authorization (if applicable) to this form and sign and date below.**

☐ I have authorization to apply for Medicaid on behalf of the applicant.
(Check the box for the type of authorization you have and submit the authorization OR complete Section D below.)

- ☐ Guardianship Document
- ☐ Power of Attorney (POA) Document
- ☐ Other Written Authorization (Specify) _____

☐ I attest that the applicant is incompetent or incapacitated. S/he is unable to sign the application herself/himself and is unable to provide written consent for me to apply on his/her behalf.

Signature of Person Completing This Form _____

Date Signed _____

SECTION D AUTHORIZATION TO APPLY FOR MEDICAID ON APPLICANT'S BEHALF

INSTRUCTIONS: If the applicant would like to provide the below authorization allowing you to represent him/her in applying for and/or renewing Medicaid, the applicant or his/her legal representative or spouse must sign the authorization below.

NOTE: If a legal representative is signing this authorization, also include the legal document giving him/her authority to act on behalf of applicant.

I authorize the person or the facility/company/agency named in **Section B** of this form to represent me in the Medicaid application and/or renewal process.

I authorize the release of necessary information/documentation between the local Department of Social Services/ Medicaid Program and the person or facility/company/agency named in **Section B** in regard to my application and/or continuing eligibility.

Signature of Applicant/Legal Representative/Applicant's Spouse _____

Date Signed _____