Appointment of an Authorized Representative

You have the right to appoint an authorized representative to act on your behalf with the Department. If you want to name a person or organization as your authorized representative, use this form.

We are committed to the privacy of your health information. Please read this form carefully.

Individual's Name:_____

Individual's Date of Birth:_____

Individual's Social Security Number:_____

Individual's Address:_____

I (individual named above) hereby appoint the following individual/organization to act as Authorized Representative for me.

Authorized Representative's Name:_____

Address: P.O. Box 1356 Bangor, Maine 04402

Telephone number:_____

Email address:_____

Existing legal authority (if any) for individual/organization to act on my behalf (check all that apply and attach copy of documentation):

_____*Guardianship*

_____*Power of Attorney*

_____*Advance Healthcare Directive*

_____*Other:*_____

By making this appointment, I want my Authorized Representative to (check all that apply):

_____Sign and submit an application on my behalf (including an elctronic application)

_____Sign and submit a recertification form on my behalf (including an electronic recertification)

_____Receive copies of Notices of Decision and all other written communications from the Department; I'm aware I may also need to complete an Authorization to Release Information form

_____Obtain Food Supplement benefits on behalf of my household

_____Act on my behalf in all other matters with the Department of Health and Human Services; I'm aware I may also need to complete an Authorization to Release Information form

- My authorized representative's authority is limited to the task or tasks I have delegated, above.
- This appointment is valid until:
  - I change this appointment in writing by notifying the Department that this Authorized Representative is no longer authorized to act on my behalf; or
  - My Authorized Representative informs the Department in writing that he/she is no longer acting as my Authorized Representative.
- I understand that taking back this appointment does not apply to any documents signed by or sent to my Authorized Representative before I took back the appointment.
- I understand that if I want my Authorized Representative to receive copies of the Notices of Decision and all other written communications from the Department, the information shared will be for all programs in which I participate that are administered by the Department.
- I understand that an appointment of a representative for the TANF or Food Supplement programs is a representative for both me and my household and that my household will be liable for any overissuance of Food Supplement or TANF benefits that results from erroneous information given by the authorized representative.

I am signing this form voluntarily, and I have the right to a signed copy of this form if I request one.

Signature of the Individual: _____ Date:_____

For the Authorized Representative

I (Individual or Organization Named as Authorized Representative) hereby agree to:

- Fulfill all above-designated responsibilities on behalf of the individual who appointed me as his/her Authorized Representative;
- Maintain the confidentiality of any information regarding the individual who appointed me as his/her Authorized Representative;
- Adhere to the regulations 42 C.F.R. § 431(F) and at 45 CFR § 155.260(f) (relating to confidentiality of information), 42 C.F.R. § 447.10 (relating to the prohibition against reassignment of provider claims as appropriate for a facility or an organization acting on the facility's behalf), as well as all other applicable state and federal laws concerning conflicts of interest and confidentiality of information.

Signature of the Authorized Representative: _____ Date:_____