

MARYLAND MEDICAL ASSISTANCE PROGRAM  
**APPLICANT WITHOUT REPRESENTATIVE WHO LACKS CAPACITY TO APPOINT  
A REPRESENTATIVE**

**INSTRUCTIONS:**

Write your name and the name of the represented party in Statements 1 and 2. Initial lines 2—6 and 9.

1. I, \_\_\_\_\_, affirm I am, in good faith, acting responsibly on behalf of \_\_\_\_\_, in his or her best interest.
2. \_\_\_\_ I declare \_\_\_\_\_ lacks legal capacity.
3. \_\_\_\_ I affirm that I will fulfill all responsibilities in the scope of this representation, including as necessary:
  - (a) Signing an application on the applicant's behalf;
  - (b) Completing and submitting a renewal form;
  - (c) Receiving copies of the applicant's or beneficiary's notices from MDH or delegated entities; and
  - (d) Acting on behalf of the applicant or beneficiary in all other matters with MDH or delegated entities.
4. \_\_\_\_ I affirm that I will resign as authorized representative if a legal guardian is appointed or a representative previously appointed by the applicant is discovered and that individual is willing to serve as the authorized representative.
5. \_\_\_\_ I affirm I will fulfill all responsibilities related to Medicaid eligibility on behalf of the represented individual.
6. \_\_\_\_ I affirm I will maintain the confidentiality of any information I receive from MDH or delegated entities regarding the individual I represent, in compliance with applicable federal and State law.

Please initial the appropriate statement below if one of the following circumstances applies. If neither is applicable, proceed to Statement 9.

7. \_\_\_\_ As an officer or employee signing for an organization as representative, I declare that the organization and its directors, employees, officers or employers, if any, do not have a direct financial interest in the above-referenced individual's eligibility for Medicaid.
8. \_\_\_\_ As an officer or employee signing for a provider of nursing home services, I declare that
  - \_\_\_\_ a. Either I and/or my organization has a direct financial interest in the disposition of the Medicaid application and
  - \_\_\_\_ b. I have diligently pursued, without success, all reasonable means of identifying a family member or any other individual or organization that is currently the authorized representative or that may be willing and able to act as authorized representative.
9. \_\_\_\_ I have disclosed in this document all potential conflicts between the best interests of the above-referenced individual and the interests of my employer, or those of any other entities or individuals I currently represent.

Signed, under penalty of perjury,

\_\_\_\_\_  
Authorized Organization (if applicable)

\_\_\_\_\_/\_\_\_\_\_  
Signature and Printed Name of Individual With Authority to Sign for Organization

\_\_\_\_\_  
Authorized Representative Name (print)

\_\_\_\_\_  
Authorized Representative Signature

\_\_\_\_\_  
Date