Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
www.mass.gov/masshealth

Eligibility Operations Memo 17-08
December 15, 2017

TO: MassHealth Eligibility Operations Staff

FROM: Amy Dybas, Deputy Chief Operating Officer for Member Policy Implementation, Training, and Communications

RE: **Change to the Definition of Authorized Representative and Revision of the Authorized Representative Designation Form (ARD)**

Summary

MassHealth revised the regulations at 130 CMR 501.000 and 515.000 and the corresponding portions of the Authorized Representative Designation Form (ARD) to clarify the role and authority of an authorized representative as well as the circumstances under which an authorized representative may be designated. In particular, the revised definition and form set forth the limited circumstances under which an authorized representative may be designated without an applicant's or member's written designation including a new signature requirement.

The changes further define the role and authority of an authorized representative regarding applications, appeals, noticing, and the representation of the estate of a deceased member as well as authorize eligible authorized representatives to serve as an appeal representative at a fair hearing consistent with federal law.

Changes to the Authorized Representative Designation Form (ARD)

The revised Authorized Representative Designation Form (ARD) provides that a written designation of an authorized representative by an applicant or member expires upon the death of such applicant or member. Further, while other authorized representatives are generally able to act on behalf of the applicant or member, the specific authorities of an authorized representative designated under Section III of the ARD (ARD III) depend on the wording of the legal appointment that creates the ARD III.

ARD Section II

Section II of the ARD allows an authorized representative to be designated for an applicant or member without the applicant's or member's signature in very limited situations where written designation is not possible, such as due to a physical or mental incapacity. Consequently, MassHealth Enrollment Center (MEC) staff must ensure all the conditions for designation of an ARD II have otherwise been met as described below.

Following the revised regulations at 130 CMR 501.000 and 515.000, an authorized representative may be designated under Section II of the ARD (ARD II) *only if* all of the following four conditions are met:

(continued on next page)

Changes to the Authorized Representative Designation Form (ARD) (*cont.*)

1) the applicant or member cannot otherwise provide written designation (such as in the case of physical or mental incapacity);
2) the applicant or member does not otherwise have an individual who can act on his or her behalf, such as an existing authorized representative, guardian, conservator, personal representative of the estate, holder of power of attorney, or invoked health care proxy;
3) the proposed ARD II is a person acting responsibly on behalf of the applicant or member; and
4) the proposed ARD II is sufficiently aware of the applicant's or member's circumstances to assume responsibility for the accuracy of the statements made on his or her behalf during the eligibility process and in other communications with MassHealth.

Therefore, the designation of an ARD II is only possible if there is not already another individual who can act on the applicant's or member's behalf on file, such as an existing authorized representative (ARD I, II, or III), guardian, conservator, personal representative of the estate, holder of power of attorney, or invoked health care proxy.

Language was also added to Section II of the ARD to make certain that any individual who wishes to be an ARD II and who is a provider, staff member, or a volunteer with an affiliation with any organization certifies that he or she will adhere to applicable state and federal laws about confidentiality and conflict of interest. Additionally, new language requires an organization-based ARD II, such as an employee of a nursing facility, to certify that the applicant or member cannot provide written designation and that they do not have any other individual who is authorized to act on the applicant's or member's behalf. This section now requires a signature from an officer of the organization to indicate acknowledgement and agreement to the requirements of ARD II.

Supplies of the ARD

The new ARD form is effective January 2018. Earlier versions of the ARD may be accepted until February 1, 2018. Although the printed version is not yet available, the form can be found on the MassHealth website and is attached to this eligibility operations memo.

Questions

If you have any questions about this memo, please have your MEC designee contact the Policy Hotline.

Authorized Representative Designation Form

You can submit this form if you would like to designate an authorized representative to act on your behalf. If an authorized representative signed your application for you, or if you are an authorized representative applying on behalf of someone else, you **MUST** submit this form for the application to be processed.

You do not need to fill out this form if you live in an institution and want copies of eligibility notices sent to you and to your spouse who still lives at home. We will do that automatically.

Note: An authorized representative has the authority to act on an applicant's or member's behalf in all matters with MassHealth and the Health Connector, and will receive personal information about the applicant or member until we receive a cancellation notice terminating their authority, or upon the death of the applicant or member. Their authority will not automatically terminate once we process your application.

You can choose someone to help you.

You may choose an authorized representative to help you get health care coverage through programs offered by MassHealth and the Health Connector. You can do this by filling out this form (the Authorized Representative Designation Form). You or a representative can sign for yourself and for any of your dependent children under the age of 18 for whom you are the custodial paren. **You are not required to have a representative in order to apply for or receive benefits.**

Who can help me?

1. An authorized representative can be a friend, family member, relative, or other person or organization of your choosing who agrees to help you. It is up to you to choose an authorized representative if you want one. Neither MassHealth nor the Health Connector will choose an authorized representative for you. You must designate in writing (fill out Section I, Part A) the person or organization who you want to be your authorized representative. Your authorized representative must also fill out Section I, Part B. We sometimes refer to this person or organization as a "Section I authorized representative."
2. If you cannot designate an authorized representative in writing and you do not have an existing authorized representative or other person who is authorized by law to act on your behalf, a person (not an organization) who certifies that he or she will act responsibly on your behalf can be your authorized representative if that person fills out Section II of this form. We sometimes refer to this person as a "Section II authorized representative."
3. An authorized representative can also be someone who has been appointed by law to act on your behalf, or on behalf of the estate of an applicant or member who has died. This person must fill out Section III and either you or this person must submit to us, together with this form, a copy of the applicable legal document stating that this person has authority to represent you, or the estate of a deceased applicant or member. We sometimes refer to this person as a "Section III authorized representative."
4. A **Section III** authorized representative may be a legal guardian, conservator, holder of power of attorney, or health care proxy, or, if the applicant or member has died, the personal representative of the estate.

What can an authorized representative do?

A **Section I** or **II** authorized representative may

- fill out your application or renewal forms;
- fill out other MassHealth or Health Connector eligibility or enrollment forms;
- give proof of information reported on these forms;
- report changes in income, address, or other circumstances;
- get copies of all of your MassHealth and Health Connector eligibility and enrollment notices; and
- act on your behalf in all other matters with MassHealth and the Health Connector.

What a **Section III** authorized representative is authorized to do for you (or for the estate of a deceased applicant or member) will depend on the wording of the legal appointment.

Please note: Eligibility notices may include information about other members of an applicant's or member's household. If there are multiple people in your household we may not be able to send copies of some of your notices to your authorized representative unless each household member has also designated the same authorized representative by completing a separate Authorized Representative Designation Form.

SECTION 1 Authorized Representative Designation (if applicant or member is able to sign)

Part A—to be filled out by applicant or member. Please print, except for signature.

Please note: Your social security number (SSN) is required if one has been issued.

Applicant's/Member's Name	SSN (if you have one) ___ ___ ___ - ___ ___ - ___ ___ ___ ___
Date of birth (mm/dd/yyyy)	Applicant's/Member's email address

I certify that I have chosen the following person or organization to be the authorized representative for myself and any dependent children under the age of 18 for whom I am the custodial parent and that I understand the duties and responsibilities this person or organization will have (as explained earlier in this form).

Applicant's/Member's signature	Date
Authorized representative's name	Authorized representative's phone number
Authorized representative's address (mailing address, city, state, zip)	

Part B—to be filled out by authorized representative. Please print, except for signature.

B1. COMPLETE IF AUTHORIZED REPRESENTATIVE IS A PERSON.

I certify that I will at all times maintain the confidentiality of any information regarding the applicant or member set forth above and, if applicable, the dependent children of such applicant or member, that is provided to me by MassHealth or the Health Connector.

If I am also a provider, staff member, or volunteer affiliated with an organization, and am acting in my capacity as a provider, staff member, or volunteer in connection with my designation as an authorized representative, I certify that I will at all times adhere to all applicable state and federal laws and regulations regarding confidentiality of information and conflicts of interest including those set forth at 42 C.F.R. part 431, subpart F, 42 C.F.R. § 447.10, and 45 C.F.R. § 155.260(f).

Authorized representative's signature	Date
Authorized representative's printed name	Authorized representative's email address

B2. COMPLETE IF AUTHORIZED REPRESENTATIVE IS AN ORGANIZATION.

I certify, on behalf of the organization set forth below, that such organization will at all times maintain the confidentiality of any information regarding the applicant or member set forth above and, if applicable, the dependent children of such applicant or member, that is provided to the organization by MassHealth or the Health Connector.

I, the provider, staff member, or volunteer of the organization set forth below, completing this form, certify on behalf of myself and on behalf of the organization I represent, that any providers, staff members, or volunteers acting on behalf of the organization in connection with this authorized representative designation will at all times adhere to all applicable state and federal laws and regulations regarding confidentiality of information, and conflicts of interest, including those set forth at 42 C.F.R. part 431, subpart F, 42 C.F.R. § 447.10, and 45 C.F.R. § 155.260(f).

Signature of provider, staff member, or volunteer completing form	Date
Printed name of provider, staff member, or volunteer completing form	
Email of provider, staff member, or volunteer completing form	Authorized representative organization name

SECTION 2 Authorized Representative Designation
(if applicant or member cannot provide written designation)

To be filled out by authorized representative. Please print, except for signature. Please provide a separate form for each applicant or member.

AN ORGANIZATION IS NOT ELIGIBLE TO BE AN AUTHORIZED REPRESENTATIVE UNDER THIS SECTION.

I certify that the applicant or member set forth below cannot provide written designation and to the best of my knowledge does not otherwise have an individual who can act on his or her behalf such as an existing authorized representative, guardian, conservator, personal representative of the estate, holder of power of attorney, or an invoked health-care proxy. In addition, I certify that I am sufficiently aware of this applicant's or member's circumstances to assume responsibility for the accuracy of the statements made on his or her behalf during the eligibility process and in other communications with MassHealth or the Health Connector, that I understand my rights and responsibilities as this person's authorized representative (as explained earlier in this form). If this person can understand, I have told the person that MassHealth and the Health Connector will send me a copy of all MassHealth and Health Connector eligibility and enrollment notices and this person agrees to this, and I have told this person that he or she may remove or replace me as his or her authorized representative at any time by the methods described earlier in this form.

I further certify that I will at all times maintain the confidentiality of any information regarding the applicant or member set forth below that is provided to me by MassHealth or the Health Connector.

If I am also a provider, staff member, or volunteer affiliated with an organization, and I am acting in my capacity as a provider, staff member, or volunteer in connection with my designation as an authorized representative, I further certify that I will at all times adhere to all applicable state and federal laws and regulations regarding confidentiality of information and conflicts of interest including those set forth at 42 CFR part 431 subpart F., 42 CFR §477.10, and 45 CFR §155.260(f).

Please note that the applicant's or member's social security number (SSN) is required if one has been issued.

Applicant's/Member's name	
Applicant's/Member's date of birth (mm/dd/yyyy)	Applicant's/Member's SSN ___ ___ ___ - ___ ___ - ___ ___ ___ ___
Authorized representative's signature	Date (mm/dd/yyyy)
Authorized representative's name (first, middle, last)	Authorized representative's phone number
Authorized representative's address (mailing address, city, state, zip)	Authorized representative's email address

If the Section II authorized representative is affiliated with an organization, and is acting in such capacity, an individual authorized to act on behalf of the organization, such as an officer, must sign below to indicate the organization's acknowledgment of and agreement with the representations and warranties made above.

Officer's Name	Officer's Title
Officer's Signature	Date (mm/dd/yyyy)

SECTION 3 Authorized Representative Designation (if appointed by law)

To be filled out by an authorized representative appointed by law (with authority to act on behalf of the applicant or member in making decisions related to health care including, but not limited to, a guardian, conservator, personal representative of the estate of an applicant or member, holder of power of attorney, or an invoked health care proxy.) Please print, except for signature. **Please submit a copy of the applicable legal document with this form.**

I certify that I will at all times maintain the confidentiality of any information regarding the applicant or member as set forth below, that is provided to me by MassHealth or the Health Connector.

Please note that the applicant's or member's social security number (SSN) is required if one has been issued.

Applicant's/Member's name	
Applicant's/Member's date of birth (mm/dd/yyyy)	Applicant's/Member's SSN ___ ___ ___ - ___ ___ - ___ ___ ___ ___
Authorized representative's signature	Date (mm/dd/yyyy)
Authorized representative's name (first, middle, last)	Authorized representative's phone number
Authorized representative's address (mailing address, city, state, zip)	Authorized representative's email address

How does an authorized representative designation end?

If you decide that you no longer want a **Section I** or **Section II** authorized representative, you must notify us at the time you want the designation to end by mail, fax, or phone. See our contact information below. If you mail or fax this notice to us, the notice must include your name, address, and date of birth, the name of your authorized representative, a statement that the designation has ended and your signature or, if you cannot provide written notice, the signature of someone acting on your behalf (in the case of a **Section II** authorized representative only).

In addition, if your authorized representative notifies us that such person or organization is no longer acting on your behalf, we will no longer recognize the person or organization as your authorized representative.

The authority of a **Section I** or **Section II** authorized representative will end upon the death of the applicant or member.

A **Section III** authorized representative's designation ends when his or her legal appointment ends. The authorized representative must notify us as instructed above.

In addition, an authorized representative's designation for a minor child ends on the child's 18th birthday.

How do I submit this form?

If you are applying for health benefits, send your filled-out Authorized Representative Designation Form to us with your application.

If you are already getting benefits, you must submit the form to us at the time you want to designate an authorized representative, or you want the declared designation to end, by

- Mailing your form to

  Health Insurance Processing Center
  P. O. Box 4405
  Taunton, MA 02780;
- Faxing your form to **1-857-323-8300**; or
- Calling us at **1-800-841-2900** (TTY: 1-800-497-4648 for people who are deaf, hard of hearing, or speech disabled).