NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Medicaid Enrollment and Exchange Integration

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 _____