MA-26
English

Department of Health
Medicaid Program
AUTHORIZED REPRESENTATIVE

Section 1

Instructions: Please complete and sign this form if you authorize another person (other than yourself) to act on your behalf with the Puerto Rico Medicaid Program. The person you authorize to act as your representative must sign, date and provide your address physical and postal in this form. You must mark the boxes for which you authorize the authorized representative to act on your behalf.

Section 2

Name of the Authorized Representative	Address (number & street, city, state, zip code)

Mark relationship with the beneficiary. Please select one (1)

☐ Attorney	☐ Family Department	☐ Relative	☐ Tutor*
☐ Institutional	☐ Friend	☐ Other (please detail)	

Activity	Description	Check the function(s) for which the representative is authorized	
Apply	• Sign the application and conduct the interview • Provide all necessary information to determine eligibility • Receive the result of the request decision • Speak on behalf of the applicant at a hearing if the decision is appealed	**Apply**	☐
Continuity	• Report changes • Attend re-determinations of the Medicaid Program • Coordinate appointments of the Medicaid Program • Receive notices of appointments and re-determinations of the Medicaid Program *NOTE*: Please do not select this activity if the representative is not going to continue acting on behalf as a representative	**Continuity**	☐

Signing this form I accept the aforementioned representation, I know the circumstances of the applicant/recipient and that this authorization can be revoke by the applicant/recipient at any time (medical documentation must be submitted if the applicant/recipient is incapable of sign this form). I understand and agree the confidentiality of all the information related to the applicant/recipient.

Signature of Authorized Representative	Date (month/day/year)	Telephone

Section 3

I, _____ authorize this person to act in my representation for the aforementioned functions and the eligibility processes that I have marked earlier. (If the applicant / recipient is medically unable to sign this authorization, please provide medical documentation that so provides). I understand that I am responsible for any information provided by anyone acting as my authorized representative, including any incorrect information. I also understand that it is my responsibility to contact the Puerto Rico Medicaid Office if at any time I wish to change the person I select as an authorized representative.

Name of the applicant/recipient	Signature of the applicant/recipient	Date (month/day/year)
Case number	**Date of birth applicant/recipient**	**Social Security of the applicant/recipient**