NEW YORK STATE OF OPPORTUNITY. | Office for People With Developmental Disabilities

# Medicare Part D
# Statement of Authority
# For Beneficiaries Who Live in Residences Certified or Operated by OPWDD

This form is to be used by a Developmental Disabilities State Operations Office (DDSOO) or an agency providing OPWDD-certified residential services to Medicare beneficiaries. It states the authority for the provider to make decisions regarding the Medicare prescription drug benefit for the beneficiaries and the basis for this authority. **The OPWDD Medicare-5 form should be used if there is a need to contact a Medicare Part D plan for a single beneficiary.**

**Instructions:**

1. Please complete this form and attach a list of the designees and the beneficiaries on whose behalf the designees may act. A DDSOO director cannot designate someone who does not work for the DDSOO to act on his or her behalf, and a director of an agency providing OPWDD certified residential services cannot designate someone who does not work for that agency to act on his or her behalf.
2. If the form will be given to a specific plan, enter the name of the Prescription Drug Plan and the Plan ID Number. Only the beneficiaries currently enrolled in the plan or who are being enrolled in the plan should be listed on the attached list of beneficiaries. (**Note** : Do not provide Personally Identifiable Information of a beneficiary who is not or will not be enrolled in the plan.)
3. Check the appropriate boxes.
4. Please print name and sign where appropriate.
5. Retain original.

| Name of DDSOO or Agency | |
|---|---|
| | |
| Name of Prescription Drug Plan | Plan ID Number |
| | |

The beneficiaries named on the attached list are over 18 years of age and are receiving residential services from the agency or DDSOO named above. None of these beneficiaries have a guardian and all of them have been determined to lack the ability to make decisions about (check all that apply):

☐ Enrollment in a Medicare Part D prescription drug plan

☐ Acting in the Medicare Part D review process. This includes filing grievances, submitting complaints, requesting and obtaining coverage determinations (including exception requests and requests for expedited procedures), filing and requesting appeals and dealing with any part of the appeals process.

Please sign below:

☐ I am the Executive Director of the Agency or DDSOO Director. Pursuant to 14 NYCRR Subpart 635-11, I am authorized to make enrollment decisions for the beneficiaries and/or act in the Medicare Part D review process if the beneficiaries lack the ability to do so. Pursuant to 14 NYCRR Subpart 635-11, I authorize my employees whose names appear on the attached list as my designees to make enrollment decisions and/or act in the Medicare Part D review process if the beneficiaries lack the ability to do so.

Name of Executive Director or DDSOO Director _____

Signature _____

Agency/DDSOO Address _____

Agency/DDSOO Telephone Number _____ Date _____

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