NYS Office for People with Developmental Disabilities

Medicare Part D
Statement of Authority
For Medicaid Service Coordination Agency

This form is to be used by a Developmental Disabilities State Operations Office (DDSOO) or an agency providing Medicaid service coordination (an OPWDD service) to a Medicare beneficiary. It states the authority for the provider to make decisions regarding the Medicare prescription drug benefit for the beneficiary and the basis for this authority.

Instructions:

1. Please complete all fields on this form. (Note: If you are enrolling the beneficiary in a plan you should not fill in a beneficiary plan ID number.)
2. Check the appropriate boxes.
3. Please print name and sign where appropriate.
4. Retain original.

Name of DDSOO or Agency

Name of Beneficiary	Date of Birth	Medicare Number

Name of Prescription Drug Plan	Beneficiary's Plan ID Number

The above named beneficiary is over 18 years of age and is receiving Medicaid service coordination from the agency or DDSOO named above. This person does not have a guardian or a willing and available spouse, parent, adult child, adult sibling, adult family member, adult friend, adult advocate or adult correspondent and has been determined to lack the ability to make decisions about (check all that apply):

☐ Enrollment in a Medicare 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 check **one** of the following and sign where appropriate:

☐ 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 beneficiary and/or act in the Medicare Part D review process if the beneficiary lacks the ability to do so.

Name of Executive Director or DDSOO Director_____

Signature _____

☐ The Executive Director of the Agency or DDSOO Director has designated me/us to enroll the beneficiary in a Medicare prescription drug plan and/or to act in the Medicare Part D review process for the beneficiary. Pursuant to 14 NYCRR Subpart 633-11, I/we are authorized to make enrollment decisions and/or act in the Medicare Part D review process if the beneficiary lacks the ability to do so.

Designee Name _____ Signature_____

Designee Name _____ Signature_____

Designee Name_____ Signature_____

Agency/DDSOO Telephone Number _____Date_____