Temporary Authorized Representative Designation (ARD) for Certified Application Counselors

Use this form if you want to give a Certified Application Counselor (CAC) temporary permission to sign your MassHealth application or renewal form when they are helping you complete the form by phone.

This form does not allow a CAC to act in any other capacity on behalf of the member, receive copies of notices, or talk to MassHealth about your benefits. A different form is needed if you would like to designate a CAC to receive information about your coverage or act on your behalf. Please fill out the Permission to Share Information (PSI) or Authorized Representative Designation (ARD) forms for this purpose.

PART A—Designation

APPLICANT/MEMBER:

First Name	MI	Last Name
Date of Birth:	MassHealth Member ID (if applicable):	
Email Address (if you already applied online, by phone, or in person and provided an email address):		

CERTIFIED APPLICATION COUNSELOR (CAC):

CAC Individual Name:			
CAC Certificate Number:	CAC Phone Number:		
CAC Email Address:	CAC Organization ID Number:		
CAC Organization Name:			
CAC Street Address:	City:	State:	ZIP:

PART B—Acceptance (To be filled out by Certified Application Counselor—please print except for signature)

By signing below, I hereby certify under the pains and penalties of perjury that I have:

- assisted the applicant or member to complete their renewal form,
- been given permission by phone to sign this renewal form on the member's behalf,
- accurately transcribed the information provided by the applicant or member named above during the renewal process, and
- fulfilled all the responsibilities within the scope of my authorization.

I will not submit any applications, forms, or proof of information on behalf of the applicant or member, or report changes in the applicant's or member's circumstances, unless authorized to do so by the applicant or member under a separate authorization form.

I understand my duties and responsibilities as this person's Certified Application Counselor, including but not limited to, disclosing any conflicts of interest, acting in the best interests of the applicant or member, and maintaining the confidentiality of information that I receive about the applicant or member (as explained earlier in this form).

Certified Application Counselor Name:	Certified Application Counselor Signature:

This Temporary ARD will end on June 30, 2025, unless you write an earlier date here. Date (mm/dd/yyyy): ___ / ___ / _____

Return this completed, signed form to:

Health Insurance Processing Center
PO Box 4405
Taunton, MA 02780

Or fax it to: (**857) 323-8300**