MMAP Client Assistance Agreement

I, _____, understand that MMAP (Michigan Medicare and Medicaid Assistance Program) is a state sponsored, nonprofit program for Medicare beneficiaries. I understand that certified **MMAP Counselors provide free, objective information** on Medicare Prescription Drug Plans, Medicare Supplemental/Medigap Policies, Medicare Advantage Plans, Long-Term Care Insurance, and eligibility for Medicaid/Medical Assistance, Medicare Savings Programs, Low-Income Subsidy, and other programs or benefits for Medicare beneficiaries. I understand that **MMAP Counselors are not affiliated with the insurance industry and do not sell, recommend, or endorse any insurance products** including Medicare Prescription Drug Plans, Medicare Advantage Plans, Medicare Supplemental/Medigap Plans or Long-Term Care Insurance Plans. I understand that **MMAP Counselors do not determine eligibility for any local, state, or federal programs or benefits**. I also understand that MMAP Counselors do not determine eligibility for any private Health Care Insurance Plans or Long-Term Care Insurance Plans. I understand that the **sole role of the MMAP Counselor assisting me is to provide me with objective, personalized information that will allow me to make an informed decision** about a Medicare Prescription Drug Plan, Medicare Advantage Plan, Medicare Supplemental/Medigap Plan, Long-Term Care Insurance Plan and/or eligibility for Medicaid/Medical Assistance, Medicare Savings Program, Low-Income Subsidy, and other public and private programs or benefits based on my own preferences and needs. I understand that the **MMAP Counselor assisting me is acting in good faith** based on personal information provided by me. **I assume full responsibility for the decisions made or actions taken by me as a result of the information and assistance provided by the MMAP Counselor**. I further understand that the MMAP counselor is giving me the most up to date information available and if I am concerned about accuracy, I will call the plan directly.

_____I authorize MMAP to create on my behalf, and for my sole benefit, a MyMedicare.gov Account.

I therefore hold harmless MMAP, the sponsoring organizations, the MMAP Counselor, and any other MMAP Team Members for any liability arising out of this service provided within the scope of responsibilities and in accordance with program guidelines.

_____ _____

Client Signature Date