MMAP Team Member Agreement

As a MMAP (Michigan Medicare/Medicaid Assistance Program) team member, I agree to act within the scope of my responsibilities and abide by all program policies and procedures as specified in, but not limited to the following: team member position descriptions, handbooks, manuals, and other guidance. MMAP Inc. and the local Area Agencies on Aging (AAA) are not responsible for any activity that I engage in or any responsibility that I assume other than those specified in the above mentioned program policies and procedures. Any action that I take outside the scope of responsibilities for my position will be taken at my own personal risk. MMAP relies upon volunteers and paid staff to serve Medicare/Medicaid beneficiaries and their community. The scope of responsibilities varies for each team member. MMAP team members provide services free of charge to any client who seeks assistance from the program.

Nature of Team Member Service

I understand that as a member of the MMAP team:

- My responsibilities may include, but are not limited to, providing accurate and objective counseling and assistance for clients that include Medicare beneficiaries, their representatives and caregivers, and persons soon to be eligible for Medicare. This may include understanding Medicare and Medicaid, Medicare Prescription Drug Coverage, Medicare supplemental insurance, Medicare health plans, Medicaid or Medicare Savings Program application, identifying and reporting Medicare and Medicaid fraud/abuse or scams, long term care insurance options, and other tasks as assigned.
- My responsibilities may include the use of internet-based programs to help clients identify and compare health and prescription drug plan options.
- I must enter documentation of my MMAP activities into a web-based reporting system or submit documentation of my activities in a format agreed upon with my local MMAP Coordinator.
- My responsibilities may also include educating the public on Medicare, Medicaid, and health insurance issues that affect older adults and people with disabilities.

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- My team member activities may need to take place at specific counseling sites, by telephone, or at clients' homes when health conditions make it necessary.
- I am making a commitment to serve a minimum number of hours per month as arranged with the MMAP local coordinator.

Confidentiality

- I understand that I will have access to certain files and other information about my clients, including medical, insurance, financial and other personal data of a sensitive or confidential nature.
- I agree to keep such information confidential and to use it only to perform my duties as a MMAP team member, to the extent that a client explicitly authorizes.

Non-Conflict of Interest

MMAP team members cannot promote private or personal interests as they go about performing the duties described in the MMAP's policies and guidelines. To comply with this requirement, I agree to the following:

- I will in no way attempt to conduct market research, or solicit or persuade clients to purchase or enroll in a specific type of health insurance coverage, to switch from one carrier to another to replace existing insurance coverage, to go to a specific provider of service for treatment, or to direct a client to a specific agent/broker, or to any profit-based billing service.
- I will not disclose or use confidential or other personal information obtained through my association with MMAP for personal gain or the gain of my employer or any other party.

Agreement

- I agree to serve in the role(s) of ______________________________________ ___________________________________ for ________ hours per month.
- I agree to attend the initial and update training programs that MMAP provides.
- I agree to respect the confidentiality of my clients and to exercise good faith and integrity in performing my duties as a MMAP team member.
- I understand that a breach of this agreement will result in the termination of my service and may subject me to liability for harm that I cause a client through a breach of confidentiality or acting outside the scope of my responsibilities.

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Team Member's Name: ____

Team Member's Signature: ____

County: ___________________________________

Date:_________________________

Coordinator's Signature: ____

County: ___________________________________

Date:_________________________

Coordinator: Please make a copy of this form for your files and send the original to MMAP, Inc.

MMAP Mission

To educate, counsel, and empower Michigan's older adults and individuals with disabilities, and those who serve them, so that they can make informed health benefit decisions.

LOCAL HELP FOR PEOPLE WITH MEDICARE

Developed by MMAP, Inc. and the Health Assistance Partnership