AUTHORIZATION TO OBTAIN AND ASSIST MEDICAID STATUS AND OR DATA IN RECERTIFICATION

_____

(Resident's Name)

If a recertification application for Medicaid is due or has been filed by the Resident or for him/her by an authorized person, the undersigned authorizes the Tolstoy Foundation Rehabilitation & Nursing Center to obtain any and all information concerning the Resident's Medicaid status and/or the data contained in the application for Medicaid and to otherwise assist in the recertification process.

Confidentiality of records will be maintained under Social Services Law.

A photocopy of this authorization may be treated as the original.

Signature: _____

(If other than Resident – give relationship)

Address: _____

_____

Work Phone: _____

Home Phone: _____

Cell Phone: _____