

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

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(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 Nursing Home 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: \_\_\_\_\_