RESET FIELDS

LONG TERM CARE SERVICE PROVIDER AUTHORIZATION FORM

CASE IDENTIFICATION				
CO	RECORD NUMBER	CAT	CTR DIG	DIST
CASELOAD NO.			WORKER I.D.	

Applicant or Recipient's Full Name _____

I _____ , allow representatives of _____ to act on my behalf and request an Undue Hardship Waiver from the Pennsylvania Department of Public Welfare (DPW). This authorization is limited in scope to representing me in requesting an Undue Hardship Waiver.

_____ _____

Signature of Applicant or Recipient *Date*

_____ _____

Signature of Authorized Representative *Date*

_____ , agrees to represent _____ in requesting an Undue Hardship Waiver from DPW. It is understood that the authorization is limited in scope to the request for an Undue Hardship Waiver.

_____ _____

Signature of Long Term Care Provider Contact (Title) *Date*