Daughters of Sarah
Nursing & Rehabilitation Center

PERMISSION FOR PAYMENTS - AUTHORIZATIONS/ RELEASES

_____ _____
(Name of Resident) (Medicare Number/ Insurance ID)

A. I hereby request that payment:

a. of authorized Medicare,
b. of authorized no fault benefits,
c. of authorized insurance carrier benefits, and
d. under any pension or similar tax deferred account or plan

be made either to me or on my behalf for any services furnished to me by or in Daughters of Sarah Nursing Center, Inc., including physician services.

I hereby authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, to the no fault carrier, to the insurance carrier, or to any of their agents any information needed to determine entitlement to these benefits or any benefits for related services.

B. I hereby authorize and direct:

a. any physician or facility who has provided medical care to me,
b. the _____ County Department of Social Services (hereafter the "Department"), and
c. any banking or financial institution, any mutual fund, any investment broker, advisor or manager, or any trustee or administrator of any pension fund (hereafter the "Institution") with whom the above-named Resident currently maintains, or at any time within the five (5) years prior to the date of this Release has maintained, any banking or investment account

to release on the above-named Resident's behalf to **DAUGHTERS OF SARAH NURSING CENTER, INC.** having a place of business at 180 Washington Avenue Extension, Albany, New York 12203, or its agents (the "Facility") (i) any and all medical or personally identifying information regarding the Resident, or (ii) any information about the above-named Resident's Medicaid case that they may have in their possession, or (iii) copies of any of the Resident's banking records, investment records and other financial information in possession of the Institution.

C. MEDICAID HARDSHIP APPLICATION

If I am unable to qualify for Medicaid benefits due to an uncompensated transfer I may have made, in addition to any rights I may have to so apply, I hereby authorize Daughters of Sarah Nursing Center, Inc. to make application on my behalf to the Office of Social Services for the appropriate county for any available Undue Hardship Waiver. In granting this authorization I recognize that the Center is not promising that it will make any such application; that the Center may do so solely in its discretion; and that the Center will have no obligation or liability to me if it elects not to so apply.

_____ _____
Signature of Resident or Resident Representative Date