

**LONG TERM CARE FACILITY AUTHORIZATION FORM**

**Applicant or Recipient's Full Name** \_\_\_\_\_

**Case Record Number** \_\_\_\_\_

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**

**DATE**

\_\_\_\_\_  
Applicant or Recipient

\_\_\_\_\_

\_\_\_\_\_  
Authorized Representative

\_\_\_\_\_

\_\_\_\_\_, 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**

**DATE**

\_\_\_\_\_  
Facility Contact (Title)

\_\_\_\_\_