NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Medicaid Enrollment and Exchange Integration

Authorization for Verification of Resources (Applicant)

This form authorizes Medicaid to request records from financial institutions for an individual applying for Medicaid.

This Authorization must be signed by the applicant if the applicant is:

- Age 65 or older
- Certified blind or certified disabled (of any age)

Please provide the information for the applicant below and sign the authorization.

Signing this Authorization is a condition of receiving Medicaid benefits. This is because eligibility depends on the amount of resources owned by the applicant. **Failure to sign and submit this Authorization may result in a denial or discontinuance of Medicaid benefits.**

I. INFORMATION FOR APPLICANT

Applicant's Name | Last Name | First Name | Middle Initial |

Social Security Number ___ – ___ – ____ Date of Birth ___ – ___ – ___

II. AUTHORIZATION

I authorize verification of my resources with financial institutions for the purpose of determining eligibility for Medicaid.

This authorization will end if my application for Medicaid is denied, or I am no longer eligible for Medicaid, or I revoke this authorization in a written statement to my local Department of Social Services.

Signature of Applicant/Legal Representative* _____

Date Signed _____

**Note: If a legal representative is signing this authorization, also include the legal document giving him/her authority to act on behalf of applicant.*