MEDICAID Coordinator
100 Patriots Road
Stony Brook, New York 11790
Phone: 631-444-8533
Fax: 631-444-8573

Medicaid Application Verification Form

To Be Completed & Returned by the THIRD PARTY RESPONSIBLE for FILING the Medicaid Application

This document confirms that Medicaid Application Services for Mr./Mrs./Ms. _____ will be provided by our organization. It will be our responsibility to complete and file the Medicaid application. The anticipated Medicaid pick-up date will be _____.

We agree and understand that the Long Island State Veterans Home Medicaid Coordinator will not be responsible for filing this Medicaid application.

We also understand and acknowledge that any missed application deadlines, failure to file a Medicaid Application or denial of Medicaid as a result of the designated representative's negligence or failure to act will result in the designated representative being billed at a daily private pay rate and responsible for payment.

X _____ _____ _____
Signature of Filing Attorney of Entity **Print Name** **Date**