Clear Form

THE STATE OF NEW HAMPSHIRE
JUDICIAL BRANCH

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Court Name: _____

Case Name: _____

Case Number: _____
(if known)

PETITION FOR SPECIAL MEDICAID REPRESENTATIVE
(RSA 151-I:2)

1. The Petitioner is a "care facility" as defined in RSA 151-I:1, I:

   Facility name: _____

   Facility address: _____

2. The Petitioner's business status is as follows: (e.g. Corporation):

   _____

3. The Person, as defined in RSA 151-I:1, is a patient or resident at the Petitioner's facility located at:

   _____

4. The Person's name is _____

   and he/she is _____ years of age.

5. The Person is not under a current order of guardianship or conservatorship.

6. The Person's adult spouse, parents, children and siblings, as known to the Petitioner, are listed below (attach additional page if necessary):

Name	Mailing Address	Relationship

7. The names/addresses of any current agents under a power of attorney over the Person's finances/assets, as known to the Petitioner, are listed below:

Name	Mailing Address

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8. The Person is represented by counsel (if known to the Petitioner):
   Name _____ Mailing Address _____

9. The Petitioner proposes that the individual listed below, who is not an employee of the Petitioner, be appointed by the Court as the Person's Special Medicaid Representative:
   Name _____ Mailing Address _____

   Occupation _____ Relationship _____

10. The Petitioner alleges the following facts which demonstrate the need for the appointment of a Special Medicaid Representative pursuant to RSA 151-I:2:

    _____

    _____

    _____

    _____

    _____

    _____

    _____

11. Attached is the affidavit of a duly-authorized representative of the Petitioner which demonstrates the basis for the Petitioner's belief that a Medicaid application is necessary and that a written request has been provided to the Person or any agents of the Person and that neither the Person nor any of the Person's agents have filed a Medicaid application with the Department of Health and Human Services or that the Person or the Person's agents have otherwise failed to cooperate with the process as required by RSA 151-I:I.

12. The Petitioner requests the appointment of a Special Medicaid Representative.

_____
Date

_____
Signature of Petitioner

_____
Printed Name of Petitioner

_____
Street

_____
City/State/Zip code