Office for Dispute Resolution

Case # 4755W-

# OFFICE for DISPUTE RESOLUTION
# Authorization of Resources

**Please complete this form and present it to the mediator assigned to this case.**

INDIVIDUAL:

COUNTY MH/MR OFFICE:

Mediation Date: **at**
The aforementioned county MH/MR office agrees to participate in mediation regarding Medicaid waivers for the aforementioned.

**I, , as**
**have the authority**

**to represent the county MH/MR office in mediation for this individual; and**

**to commit whatever resources necessary for this individual as a result of the mediation session.**

_____ _____

Signature: Chief County MH/MR Administrator Date

_____

Print name and title of Chief County MH/MR Administrator

6340 Flank Drive, Harrisburg, PA 17112-2764
717-541-4960 • Toll Free 800-222-3353 (PA only) • Fax 717-657-5983 • TTY 800-654-5984 • ODR.pattan.net