



## LIMITED POWER OF ATTORNEY

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I, \_\_\_\_\_, do hereby make and appoint \_\_\_\_\_  
Name of Facility's Administrator (Printed) Name of Agent

as my true and lawful attorney in fact for me and in my name solely for the purpose of signing the Billing Certification located on the last page of Form HFS 194-M-1, Remittance Advice, and Form HFS 2234, Bed Reserve Form.

The agent is employed at the facility and will, before signing Form HFS 194-M-1, assure the accuracy of the payment received.

This limited power of attorney shall remain in effect until such time as the Illinois Department of Healthcare and Family Services is notified in writing that it has been revoked.

This authorization in no way limits the facility's or my rights, liabilities or duties relating to the provisions of service under the Illinois Department of Healthcare and Family Services Medical Assistance Program. I accept full responsibility for all payments received from the Illinois Department of Healthcare and Family Services under my name on Form HFS 194-M-1 and Form HFS 2234.

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Name of Facility

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Address of Facility

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Signature of Facility Administrator

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Date

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Signature of Agent

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Date

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Printed Name of Agent