



Authorized Representative Designation and Affidavit

Designation of Authorized Representative

_____, hereby designates:

_____ Full Name of Client	_____ Client's Medicaid ID		
_____ Full Legal Name of Authorized Representative	_____ Date of Birth	_____ Last 4 digits of SSN	
_____ Street Address	_____ City	_____ State	_____ Zip
_____ Telephone Number	_____ Email Address		

To serve as my Authorized Representative (AR) while receiving benefits under the Consumer Directed Attendant Support Services (CDASS) to handle the following tasks:

- Complete & Sign Forms
 Attend Training
 Budgeting
 Personnel Issues
 Plan & Organize Attendant Support
 Other: _____

If the client's Physician has indicated on the Physician Statement of Consumer Capability that he or she **cannot direct his or her own care then the AR must handle ALL tasks.**

I understand that the AR receives no monetary compensation for this service and I further understand that my AR cannot be a paid attendant.

Person completing this form is (check one): Client Legal Guardian
 If Legal Guardian, please submit documentation.

Client or Legal Guardian Signature Date

In case of the client's inability to sign, another person may witness the client's mark above.

Print Full Name of Witness Date

Authorized Representative Affidavit

I hereby agree to serve as the Authorized Representative for the above named client and understand my responsibilities and duties. In addition,

- a) I am at least eighteen years of age;
- b) I have known the client for at least two years;
- c) I have not been convicted of any crime involving exploitation, abuse, or assault on another person; and
- d) I do not have a mental, emotional, or physical condition that could result in harm to the client.

Authorized Representative Signature Date

Print Full Name of Witness Date

