AD*vantage* Program
Consumer-Directed Personal Services and Supports (CD-PASS)
Designation of Authorized Representative

Consumer Information

_____ _____ / _____ / _____
Medicaid ID Number Date of Birth

_____ _____ _____
Last Name First Name M.I.

Designation of Authorized Representative

Please check the ☐ **Yes** or ☐ **No** box indicating your agreement with and acknowledgment of the following:

1. I understand that I may designate a family member or friend as an Authorized Representative to assist me in my responsibilities to the extent that I prefer. My Personal Services Assistance may not be my designated Authorized Representative. ☐ Yes ☐ No

   I understand that if I choose an Authorized Representative, I am not giving up any of my decision-making authority. I understand that I may change my mind and revoke my designation of an Authorized Representative at any time by notifying my Consumer Directed Agent.

2. I want to designate an Authorized Representative to assist me in receiving CD-PASS services. ☐ Yes ☐ No

   I have discussed the specific assistance I would like from my designated Authorized Representative. I give my permission for members of my CD-PASS support team to contact my designated Authorized Representative listed below:

   If yes, provide the following information:

   _____ _____ _____
   Last Name First Name M.I.

   _____
   Address

   _____ _____ _____ (____) ____-_____
   City State Zip Phone

   I agree to serve as the Consumer's designated Authorized Representative.

   _____ _____
   Authorized Representative Signature Date

_____ _____
Signature of Consumer Date

_____ _____
Signature of Provider Date