

Participant Name: _____

Authorized Representative Designation (please check only one box in this section)

By signing below, I attest that:

- I, _____ (*Participant*), authorize
_____ (*Representative*) to act as my Authorized
Representative to assist me in directing and managing my Participant-directed
Services (PDS) on my behalf.
- My legal guardian, _____ (*Legal Guardian*), has authorized
_____ (*Representative*) to act as my Authorized
Representative to assist me in directing and managing my PDS on my behalf.
- The person granted power of attorney for me, _____ (*Power
of Attorney*), has authorized _____ (*Representative*) to act as
my Authorized Representative to assist me in directing and managing my PDS on my
behalf.

Authorized Representative Responsibilities and Attestation

I, _____ (*Representative*), understand and agree with my role as
the Authorized Representative, including being the common law employer of the participant-
directed worker(s) (PDWs) hired by _____ (*Participant*). I
understand that my appointment as Authorized Representative may be revoked at any time by
the Participant, myself, or the Department of Health Care Finance (DHCF).

By reviewing and initialing this section, I affirm that I meet all of the requirements, as listed
below, to be the Authorized Representative for the above-named Participant, who is enrolled
in and receiving services from the *Services My Way* program.

1. I am at least 18 years of age.
2. I know the Participant very well.
3. I understand the kinds of services the Participant needs and how s/he wants services
to be provided.
4. I know the Participant's schedule and routine.
5. I know the Participant's health care needs and the medicine s/he takes.
6. I am willing and able to do all of the duties that are required to be an Authorized
Representative.



7. I will be present in the Participant's home often enough to be able to properly supervise staff.
8. I understand that I cannot be paid to be an Authorized Representative.
9. I understand that I cannot be a paid PDW for the Participant if I serve as his/her Authorized Representative.
10. I understand that I may not be an Authorized Representative for more than one (1) *Services My Way* program participant at any one point in time.

_____ (Representative Initials)

II. As the common law employer, I will be responsible for most of the tasks that any other employer would perform, with payroll and bill payment assistance from the Vendor Fiscal/Employer Agents (F/EA) Financial Management Service (FMS)-Support Broker entity.

By reviewing and initialing below, I understand and agree to do these tasks:

1. Make decisions and perform tasks on the Participant's behalf that are:
 - a. In his/her best interest,
 - b. In a manner that truly reflects the Participant's wishes and how he/she would perform them in the absence of his/her disability or chronic condition, and
 - c. Increasing the Participant's independence and community integration.
2. Accommodate the Participant, to the extent necessary, so that the Participant can participate as fully as possible in all decisions that affect the Participant.
 - a. Accommodations must include, but not be limited to, communication devices, interpreters, and physical assistance.
3. Give due consideration to all information including the recommendations of other interested and involved parties.
4. Develop, with the Participant, a job description and recruit, interview and hire PDWs to provide services to the Participant.
5. Decide, with the Participant, how much PDWs will be paid (within limits set by the DHCF).
6. Establish, with the Participant, the PDWs' job duties and work schedules.



7. Train, with the Participant, PDWs to provide services based on the Participant's needs and preferences.
8. Develop and implement, with the Participant, an emergency back-up PDWs and natural supports plan and update it, as needed.
9. Designate and activate, with the Participant, emergency back-up PDWs and natural supports persons, as needed.
10. Review/approve, with the Participant, and sign and submit PDWs' timesheets in an accurate and timely manner to the Vendor F/EA FMS-Support Broker entity.
11. Prepare Biweekly Progress Notes with the PDWs and maintain required documentation in the home including *Biweekly Progress Notes* on the services being provided by PDWs
12. Make sure PDWs provide only the amount of service as designated in the Participant's approved waiver person-centered plan and PDS budget.
13. Supervise, with the Participant, his/her PDWs.
14. Evaluate, with the Participant, the PDWs' job performance.
15. Address, with the Participant, problems or concerns with PDWs' performance.
16. Fire, after discussion with the Participant, PDWs for cause, when necessary.
17. Prepare and submit a *Status Change Form* to the Vendor F/EA FMS-Support Broker entity when a PDW's contact information changes or when terminated from employment for any reason within 24 hours of termination.
18. Maintain compliance with federal and state tax, insurance and DHCF's *Services My Way* program and §1915(c) EPD Waiver rules and requirements and Vendor F/EA FMS-Support Broker entity requirements.

_____ (Representative Initials)

III. I understand and willingly accept all of the responsibilities of serving as an Authorized Representative for the listed Participant.

I understand that I will receive support from the Vendor F/EA FMS-Support Broker entity while performing as the Authorized Representative and common law employer of the Participant's PDWs. However, the Vendor F/EA FMS-Support Broker entity cannot hire,



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**AUTHORIZED REPRESENTATIVE
DESIGNATION FORM**

train, supervise or fire the Participant's PDWs; I understand that I, with the Participant as appropriate, am responsible for hiring, training, supervising, or firing the Participant's PDW.

By signing below, I affirm that I have completed this Agreement. I have read and understood my responsibilities, and agree to perform all responsibilities of an Authorized Representative as defined above.

Signature of Participant

Date

*Signature of Legal Guardian/
Power of Attorney (if applicable)*

Date

Signature of Authorized Representative

Date

Signature of Support Broker

Date

