COLORADO
Department of Health Care Policy & Financing

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**

_____ _____ _____

Phone (home) **Phone (mobile)** **Email Address**

☐ Please contact me via email or text message with updates about CDASS (standard carrier rates may apply to texts)

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 <u>cannot</u> 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 **Witness Signature** **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 **Witness Signature** **Date**