Health First COLORADO™
Colorado's Medicaid Program

Consumer Directed Attendant Support Services (CDASS) Authorized Representative Designation

Health First Colorado members can choose an Authorized Representative (AR) to help them with CDASS benefits and tasks, if the member is enrolled in a waiver that offers CDASS. Members may change their AR at any time. If the member wants to change their AR, they must work with their case manager to make the change. This form must be completed each time the member changes their AR.

Authorized Representative: An individual chosen by the member, or by legal guardian of the member. The AR must have the judgment and ability to help the member obtain and use services. The extent of the AR's involvement shall be decided after they become the AR. The AR cannot also be the member's attendant. State laws dictating AR designation for CDASS can be found in Colorado Revised Statute CRS 25.5-6-1101.

Designation of Authorized Representative
I hereby designate the following person to serve as my AR while receiving benefits under CDASS. I understand my AR will do these things for me: • Complete and sign forms • Attend training • Budgeting • Plan & organize attendant support If the member's physician has indicated on the Physician Statement of Consumer Capability form that the member cannot direct their own care, then the AR must handle ALL tasks.

Member Information		
Last Name:	First Name:	Middle Initial:
Health First Colorado ID#:	Date of Birth (MM/DD/YYYY):	
Street Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	
Email:		

Authorized Representative Information		
Name:	Relationship: ◯ Relative ◯ Not a relative	
Date of Birth (MM/DD/YYYY):	Last 4 digits of SSN:	
Street Address:		
City:	State:	Zip:
Home Phone:	Cell Phone:	
Email:		
☐ Please contact me by email or text message with updates about CDASS (standard carrier rates may apply)		

Authorized Representative Affidavit	
I hereby agree to serve as the Authorized Representative for the above-named member and understand my responsibilities and duties. In addition, a) I am at least eighteen years old; b) I have known the member 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 member.	
Authorized Representative Signature:	**Date:**

Member or Legal Guardian Signature	
Person completing this form: ◯ Member ◯ Legal Guardian (If legal guardian, please submit documentation)	
Member or Legal Guardian Signature:	**Date:**
If the member is unable to sign, another person may witness the member's mark above.	
Witness Name:	
Witness Signature:	**Date:**