COLORADO
Department of Health Care Policy & Financing

Consumer Directed Attendant Support Services (CDASS)
Authorized Representative Designation

Designation of Authorized Representative

Client Name:	Medicaid ID:

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

☐ Complete and sign forms

☐ Attend training

☐ Budgeting

☐ 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.

Authorized Representative Information

Name:	Date of Birth:	Last 4 digits of SSN:
Address:	City:	State & Zip:
Home Phone:	Cell Phone:	Email:

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

Person completing this form: ☐ 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.

Witness Name:	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: