

**AUTHORIZED REPRESENTATIVE DESIGNATION
MEDICAID COMMUNITY WAIVER PROGRAMS
Individualized Service Plan (ISP) ONLY**

(NOT to be used for financial eligibility documents: re. F-20919 or COP Cost Share Worksheets.)

Instructions: It is preferable to have the applicant/recipient sign documents relating to the Medicaid Community Waiver Programs with either a signature or mark to indicate his/her expressed preferences. (Those persons experiencing cognitive difficulties should be evaluated to see if another method is more appropriate.) However, the applicant/recipient may designate someone to sign the ISP on his/her behalf by completing the following form. If signed by an "X" or other mark, this form must be witnessed by two persons. The designated authorized representative and/or the case manager may act as witnesses should the applicant/recipient sign by an "X."

I authorize _____ to represent me and to act on my behalf and
(Print Full Name)

best interest in my application for the Medicaid Waiver Program. I have been consulted in the design of my service plan and my preferences are known to my representative.

SIGNATURE – Recipient / Applicant

Today's Date

SIGNATURE – Witness

Today's Date

SIGNATURE – Witness

Today's Date

I agree to represent _____ in his/her application to the Medicaid
(Print Applicant's Name)

Waiver Program. I have consulted with him/her and know what kinds of services are needed or desired.

SIGNATURE – Authorized Representative

Today's Date

SIGNATURE – Witness

Today's Date