DHS
Oregon Department
of Human Services

Office of Developmental Disabilities Services

Appointment of Designated Representative
For Adults with Intellectual and Developmental Disabilities

Individual's Name:
Designated Representative:
Relationship to the Individual:

To be completed by the Appointed Designated Representative:

By signing below, I indicate:

1. I am an adult 18 years of age or older

2, I understand and agree to direct Community First Choice (K Plan) services for the above named individual while engaging and supporting the individual, as much as possible, in choice and self-direction.

3. I understand that as the designated representative, I do not have authority, unless otherwise authorized, to act on the above named person's behalf in situations other than the provision of Community First Choice services provided through the Oregon Department of Human Services.

4. As a Designated Representative, I acknowledge that I am prohibited from being paid with Medicaid dollars to provide supports to the individual represented.

Printed Name:	**Signature:**
Email Address:	**Telephone Number:**
Address:	

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To be completed by the Individual receiving CFC (K Plan) Services:

If the individual is unable to sign this appointment, a third party witness must sign. The third party witness may not be the Services Coordinator or Personal Agent.

By signing below, I acknowledge the following:

1. I have chosen the above named person to act as my Designated Representative for the purpose of directing Community First Choice (K Plan) services;

2. This appointment lasts for one year from the date of my signature unless I revoke this authorization earlier.

3. I can revoke this authorization at any time before its expiration by informing my Services Coordinator or Personal Agent that I wish to revoke this authorization.

4. I understand that the Oregon Department of Human Services, my Services Coordinator or my Personal Agent with supporting documentation may revoke this authorization if they determine that my designated representative is not acting in my best interest or if they uncover that the appointed designated representative has a conflict of interest.

5. If I have a guardian providing paid supports, the designated representative may also act as employer of record, unless I have an employer of record already established, to verify the hours of paid supports provided to the above named individual.

Individual's Signature:	**Date:**
Witness Signature:	**Date:**
Services Coordinator/Personal Agent:	**Date:**