Kansas
Department for Aging and Disability Services

# Home and Community Based Programs

## Appointed Designated Representative Form

**(Effective: _____ to _____)**

## To be completed by the Individual receiving HCBS Program Services:

By signing below, I understand the following:

1. I have chosen the below-named person to act as my Designated Representative for the purpose of directing my Home and Community Based Services as identified in my integrated service plan of care;

2. This appointment lasts no longer than one year from the date of my signature; or as indicated by the effective dates above; or unless I cancel this consent earlier.

3. I can cancel this consent at any time before its expiration by information my Care Coordinator or Financial Management Services Provider that I wish to cancel this consent and by completing and signing the Revocation of Designated Representative form.

4. I understand that with supporting documentation this consent may be cancelled if it is determined that my designated representative is not acting in my best interest, does not show the ability to self-direct my services according to the integrated service plan of care or the HCVBS program requirements, or if it is discovered that the appointed designated representative has a conflict of interest or has committed fraud, waste, and abuse.

Participant Signature _____ Date: _____

Printed Name _____ ☐ Participant Cannot Sign

Guardian/DPOA Signature _____ Date: _____

☐ Guardian Documents Attached ☐ DPOA Documents Attached

*If the individual is unable to sign this appointment, a third party witness must sign. The third party witness may not be the Care Coordinator, Community Service Provider, Targeted Case Manager, Personal Care Attendant or the Designated Representative.*

Witness Signature _____ Date: _____

Printed Name _____

Relationship _____

# Home and Community Based Programs
# Appointed Designated Representative Form
# (Effective: _____ to _____)

## To be completed by the Appointed Designated Representative:

Name _____

Address _____

Phone _____

Email _____

Relationship to Participant _____

By signing below, as the designated representative, I certify:

1. I am an adult 18 years of age or older.
2. I am not prohibited from serving as a designated representative based on a background check, abuse, neglect and exploitation check or Office of Inspector General Medicaid exclusion list check.
3. I understand and agree to direct home and community based services for the above named individual while engaging and supporting the individual, as much as possible, in choice and self-direction.
4. 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 as the employer for directing home and community based services provided through KanCare.
5. I understand that as the designated representative, I have the duty to perform my duty and responsibility as the employer to hire, fire, manage, train, and monitor the direct service worker(s) and ensure compliance with program, state and federal rules and regulations on behalf of the participant without compensation.
6. I acknowledge that as the designated representative, I am prohibited from being paid with Medicaid dollars to provide supports to the individual represented.

Participant Signature _____ Date: _____

Printed Name _____ ☐ Participant Cannot Sign

Representative Signature _____ Date: _____

Printed Name _____