Wyoming Long Term Care Home and Community Based Waiver
Consumer Directed Care Option

Request for Review of Authorized Representative Status

Name of Participant: _____

Name of Proposed Representative: _____

Address:_____

Phone #: (_____)_____Relationship:_____

How often you have contact with the participant?

_____

_____

Do you receive money from the participant or anyone else to care for the participant?
Yes: _____ No: _____

If yes, please identify the source and purpose of the funds?

_____

_____

Do you understand your functions and responsibilities as the participant's representative?
Yes: _____ No: _____

Do you understand that you cannot pay yourself for this role and cannot become a paid employee under this option?
Yes: _____ No: _____

I have attached a copy of the "*Advanced Health Care D*irective" and the "*Durable Power of Attorney for Health Care*" which document my authority as an alternative decision maker for health care options.

By signing below you are stating that if approved by the Department, you will serve in this capacity.

_____

Signature of Proposed Representative **Date**

DEFINITION:

A representative is the person designated to make health care decisions in an *"Advance Health Care Directive"* document.

A representative must:

- **Be willing and able to assume responsibility for all activities required of Consumer Directed Care participants.**
- **Live in adequate proximity to the participant to assure you are available to respond in person to employee issues or needs of the participant.**

A representative CANNOT:

- **Be paid for this service.**
- **Delegate or assign responsibilities under this option to another person.**