Community First Choice
Authorization of Representative Form

Participant Name: ____________________________________________

Representative Name: ____________________________________________

Relationship to Participant (check one): _____ Family Member       _____ Other

Describe relationship: ____________________________________________

By signing this form, I authorize the representative listed on this form to complete certain activities related to the provision of Community First Choice services.

I understand that my representative CANNOT serve as my paid personal assistance provider. I also understand that by filling out this form, I am appointing a representative for those activities indicated below only, and NOT a representative for any other program or legal purpose.

Please mark the box next to each act that you would like your representative to take on your behalf:

_____ Help develop your Plan of Service

_____ Sign your Plan of Service on your behalf

_____ Provide Training and guidance to your personal assistance provider(s)

_____ Hire and dismiss your personal assistance provider(s)

Set hourly rate(s) for personal assistance provider(s), when applicable, within Department limitations

Participant’s Signature: __________________________        Date: ________________________

Representative’s Signature: __________________________       Date: ________________________