DESIGNATION OF RESPONSIBLE REPRESENTATIVE

Requestor/Applicant/Participant Name (print):	
Last 4 digits of SSN:	**DOB:**

I, _____, understand that the role of the responsible
(Participant's printed name)
representative(s) is to accompany, assist, and represent me in the Home and Community-Based Services assessment, care planning, and service delivery processes. The responsible representative should assist in gathering all necessary information for these processes. I understand that I **DO NOT** have to name anyone as a responsible representative. If I do name someone, I understand that I still have the right and the responsibility to actively take part in my assessment, care plan, and service delivery.

I understand this may require the Louisiana Department of Health (LDH) to give information to the representative(s) named below that may otherwise be personal and confidential. I hereby waive my rights to prevent sharing of information by LDH with the responsible representative(s) named below. I hereby allow LDH to share with my responsible representative(s) only the information necessary for him/her to perform the functions described above.

I understand that I am designating only the person(s) named below, and that they remain my representative until LDH or its contractors receive a written statement or form from me stating that this person is no longer my representative. **I understand that the person(s) I name as my responsible representative(s) may NOT be my paid direct service worker(s). I understand that the person(s) I name as my responsible representative(s) may NOT serve as the responsible representative(s) for more than two (2) individuals receiving Medicaid Home and Community-Based Services operated by the Office of Aging and Adult Services.**

I understand that while some of the information gathered may have no impact on assessment, care plan and service provision processes, it may affect my liability to a third party should this information be disclosed to the third party by my responsible representative(s). I hereby hold harmless and agree to indemnify LDH from any claim resulting from disclosure of information to a third party by my responsible representative(s).

INFORMATION & SIGNATURES

Requestor/Applicant/Participant Name (print):	
Last 4 digits of SSN:	DOB:

Responsible Representative Name:	
Last 4 digits of SSN:	DOB:
Relationship to Requestor/Applicant/Participant:	
Address:	
Home Phone #:	Other Phone(s) #:

(OPTIONAL)

2nd Responsible Representative Name:	
Last 4 digits of SSN:	DOB:
Relationship to Requestor/Applicant/Participant:	
Address:	
Home Phone #:	Other Phone(s) #:

REQUIRED:

Attestation for Responsible Representative(s): By signing below, I agree to be the designated responsible representative(s) for this participant. I understand that I may **NOT** be the participant's paid direct service worker. I also attest that I am not the representative for more than 2 individuals in any Medicaid Home and Community-Based Service.

Signature of Requestor/Applicant/Participant: _____ _____
(Date)

Signature of 1st Responsible Representative: _____ _____
(Date)

Signature of 2nd Responsible Representative: _____ _____
(If Applicable) (Date)

Signature of OAAS Designee: _____ _____
(Date)