

DESIGNATION OF AUTHORIZED REPRESENTATIVE

I am unable to purchase and/or manage the supports I need to remain in my home. I would like:

NAME		
ADDRESS		
CITY	STATE	ZIP
PHONE	FAX	

to represent me with the Consumer Support Grant Program.

We both understand that this person will:

1. Complete and sign all forms for me.
2. Submit requested program information.
3. Manage my CSG funds.
4. WITHIN 10 DAYS, report any changes in my situation that would affect my Consumer Support Grant eligibility, including but not limited to:
 - Hospitalizations, nursing home placements or any interruptions in service;
 - Any significant medical changes or problems;
 - Change of address;
 - Change in income;
 - Any changes that affect the status of my Budget and Service Agreement; and
 - Any changes that affect the status eligibility for Medical Assistance (MA).
5. Insure that Consumer Support Grant funds are only used to purchase the supports listed on the CSG Budget/Service Agreement Form.
6. Abide by all the terms and conditions of the Consumer Support Grant Program

Must be Signed and Returned

The consumer should sign on the appropriate signature line. If the consumer is unable to legibly write their name, two people should witness the signing. If the consumer cannot sign, the representative should write "unable to sign" on the consumer signature line.

Consumer's
signature _____ Date _____

Authorized rep
signature _____ Date _____

Witness
signature _____ Date _____

Witness
signature _____ Date _____

Local agency
signature _____ Date _____