

**AUTHORIZED REPRESENTATIVE DESIGNATION  
MEDICAID COMMUNITY WAIVER PROGRAMS  
Individualized Service Plan (ISP) ONLY**

**(NOT to be used for financial eligibility documents: re. F-20919 or COP Cost Share Worksheets.)**

**Instructions:** It is preferable to have the applicant/recipient sign documents relating to the Medicaid Community Waiver Programs with either a signature or mark to indicate his/her expressed preferences. (Those persons experiencing cognitive difficulties should be evaluated to see if another method is more appropriate.) However, the applicant/recipient may designate someone to sign the ISP on his/her behalf by completing the following form. If signed by an "X" or other mark, this form must be witnessed by two persons. The designated authorized representative and/or the case manager may act as witnesses should the applicant/recipient sign by an "X."

I authorize \_\_\_\_\_ to represent me and to act on my behalf and  
(Print Full Name)  
best interest in my application for the Medicaid Waiver Program. I have been consulted in the design of my service plan and my preferences are known to my representative.

|   |                       |
|---|-----------------------|
| _____<br><b>SIGNATURE</b> – Recipient / Applicant | _____<br>Today's Date |
| _____<br><b>SIGNATURE</b> – Witness               | _____<br>Today's Date |
| _____<br><b>SIGNATURE</b> – Witness               | _____<br>Today's Date |

I agree to represent \_\_\_\_\_ in his/her application to the Medicaid  
(Print Applicant's Name)  
Waiver Program. I have consulted with him/her and know what kinds of services are needed or desired.

|   |                       |
|---|-----------------------|
| _____<br><b>SIGNATURE</b> – Authorized Representative | _____<br>Today's Date |
| _____<br><b>SIGNATURE</b> – Witness                   | _____<br>Today's Date |