NORTH CAROLINA
HOME CARE INDEPENDENCE PROGRAM

APPOINTMENT OF REPRESENTATIVE FOR PARTICIPANT

Participant Name: ________________________________

Participant Address: ______________________________

The above named person (Participant) is interested in receiving Consumer Directed Services (CDS) and wants to appoint another person, called a Representative, to act in his/her behalf for selecting, training, and directing Personal Assistants that they will hire for direct provision of care to them in their home setting, in addition to working cooperatively with the Care Advisor and Financial Management Service involved in the person's care.

Questions for the individual being considered for the volunteer position of Representative:

1. What is your relationship to the Participant?
   Family Member __ Friend __ Legal Guardian __ Other __

2. Do you receive money from the client or anyone else to care for the person? Yes __ No __
   If Yes, you will be unable to act in the capacity of Representative in the CDS program of the NC Division of Aging and Adult services unless you are willing to give up the paid care giving responsibilities.
   Are you willing to give up the paid position? Yes__ No__
   If Yes, please proceed to the following questions.

3. After reading the following duties and responsibilities, please indicate your understanding and acceptance by initialing each statement:
   a. ___ Accept responsibility to monitor the health care needs of this person and to seek help with issues from an appropriate health care person whenever this becomes necessary
   b. ___ Work cooperatively with the Financial Management Service (FMS) that will provide payroll and other financial services for the person by verifying the provision of service by Personal Assistants who work with the person
c. ___Supervise the work of Personal Assistants
d. ___Show a strong personal commitment to the person
e. ___Show knowledge about the person and their personal preferences
f. ___Show sound judgment to act on the person’s behalf
g. ___Be at least 18 years of age
h. ___Have known the person for at least two years
i. ___Do not have a convicted felony record of abuse, neglect, assault, criminal sexual conduct, fraud, or theft against a minor or adult
j. ___Understand that I may not receive money to be the Representative of the person
k. ___Cannot serve as the Personal Assistant of the person
l. ___Do not have a mental, emotional, or physical condition that could result in harm to the person

4. Do you understand that as this person’s Representative you cannot be both a paid Personal Assistant and the Representative? Yes ___ No ___

I wish to appoint this person to serve as my Representative while I am a Participant in the Consumer Directed Services program.

Signature ________________________________ Date ___________

(Participant)

I accept the volunteer position of Representative for the above person.

Signature ________________________________ Date ___________

(Representative)

Address_____________________________________________
Telephone ____________________________

I have witnessed the signatures of the Participant and Representative.

Signature ________________________________ Date ___________

(Care Advisor)

Eff. 7/1/11……… a copy goes to each person who has signed this form and to the FMS