PO Box 13260
Maumelle, AR 72113
Toll Free 877-710-0457
Online: PalcoFirst.com

Participant Authorized Representative Designation Form

Complete this form entirely to designate an authorized representative (AR). An AR may be a participant's legal guardian, a family member, or any other individual identified who willingly accepts responsibility for performing tasks the participant cannot perform. An AR must have a personal commitment to the participant and must be willing to follow their wishes and respect their preferences while using sound judgment on their behalf. Authorized representatives receive no monetary compensation for this service and may not serve as a worker to the participant.

PARTICIPANT INFORMATION			
First Name	Middle Name	Last Name	Medicaid ID #

DESIGNATED AUTHORIZED REPRESENTATIVE INFORMATION			
First Name	Middle Name	Last Name	
	Date of Birth		
Relationship to Participant			
Mailing Address (Street Address, including Apt #)			
City	State	Zip	County
Phone	Email		

Type of Authorized Representative (Choose One)

☐ **Voluntary** (*The participant requests that representative serve on their behalf, or a Support Counselor recommends that the participant designate a representative and the participant agrees.)*

☐ **Predetermined** *(The participant has a legal guardian or other court appointed representative in place at the time of enrollment and that individual will serve as the designated representative on the client's behalf.)*

☐ **Mandatory** *(The client is enrolled in Personal Preferences and has misspent funds from the cash allowance, or their functioning has deteriorated in such a way that they are no longer able to manage their cash benefit)*

As the designated authorized representative, I agree to:

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- Work with the Support Counselor to provide information to develop the Cash Management Plan (CMP) on the participant's behalf.
- Help ensure that the cash grant is used for the items outlined in the Cash Management Plan, taking into account the participants' wishes.
- Maintain records, as required by the State, regarding planned expenditures. This includes ensuring that worker timesheets and non-labor invoices are completed, signed, and submitted to the Fiscal Management Service for processing.

I also attest that I meet the eligibility to fill this role, including:

- I am over the age of 18.
- I live in New Jersey and/or within 1 hour or 30 miles from the participant.
- I am willing and able to physically visit the participant in their home to observe their care needs being met at least once per pay period (every two weeks).
- I am not currently a paid worker for the participant in the Personal Preference Program.
- I do not have a history of physical, mental, or financial abuse of another participant.

By completing this form and signing below, the participant agrees to designating the individual named above as their authorized representative for the Personal Preferences Program. The AR will complete and sign all forms and send information to the Support Counselor as requested. The AR will use Personal Preference Program funds to purchase the support listed on the Cash Management Plan as directed and will ensure that all items are purchased and services arranged are paid. We understand that the AR cannot receive any monetary compensation for this service.

_____ _____

Authorized Representative Printed Name **Participant Printed Name**

_____ _____

Authorized Representative Signature **Participant Signature**

_____ _____

Date **Date**

Please return this form to Palco via email: enrollNJ@palcofirst.com or via fax to 1.877.859.8757