



**Community Choices
Home and Community Based Service Waivers**

**Participant Directed Care Option
Authorized Representative Review**

Name of Participant: _____

Medicaid Number: _____ Phone: () _____

Address: _____

City: _____ Zip: _____

Designated Representative

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Case Manager Name: _____ Case Manager Signature: _____

Date: _____

For Waiver Office Use Only:

- Information has been reviewed regarding this participant. The request **HAS BEEN APPROVED** for the designated representative identified above to serve as the representative under the Participant Directed Care option.

- Information has been reviewed regarding this participant. The request **IS NOT APPROVED** for designated representative identified above to serve as the representative under the Participant Directed Care option.

Program Manager or Designee _____ Date _____
Community Choices Home and Community Based Waiver