



OKLAHOMA DEPARTMENT OF HUMAN SERVICES

**ADvantage Program**  
**Consumer-Directed Personal Assistance Services**  
**and Supports (CD-PASS)**



**CD-PASS Designation of Authorized Representative**

**Instructions**

Please fully complete all sections of this form, as applicable. This information is required for application to the CD-PASS service option and for annual reassessments.

**Member Information**

_____	_____	_____	_____
Member last name	First name	Middle name	Medicaid number
_____			( ) -
Street address			Phone Number
_____	_____	_____	_____
City	County	State	Zip

**Definitions**

ADvantage Members may designate someone to assist them to manage their employer responsibilities in the CD-PASS service option. Representation is required if mental status is high risk, combined UCAT III score is high risk, or if recent self-neglect or self-abuse occurred. The following are the most common types of representatives:

**Authorized Representative (AR):** An individual appointed by the Member to assist, counsel, or advise the Member regarding any or all CD-PASS activities and take actions on behalf of the Member when directed by the Member. The Authorized Representative may not sign or make decisions for the Member, unless the Authorized Representative is also the Power of Attorney or Legal Guardian.

**Power of Attorney (POA):** A notarized instrument granting an individual the authority to act as a legal agent or attorney-in-fact for the Member. The purpose of a Power of Attorney is to give the person the Member designates legal authority to sign and make decisions on the Member's behalf, as indicated in the POA document.

**Legal Guardian (LG):** An individual who has the legal authority and duty to care for the Member's person or property. This designation must be in writing and approved by a judge.

## Representative

Complete this section with information about your representative. You may use this section to appoint an Authorized Representative (AR). Please select "None" if you do not have a representative and do not wish to appoint one.

Check one:

AR only    POA\*    LG\*    None (if none, skip to page 3)

**\*If POA or LG, attach copy of legal papers to this form.**

\_\_\_\_\_  
Representative's Last name

\_\_\_\_\_  
First name

\_\_\_\_\_  
Middle name

\_\_\_\_\_  
Representative's Mailing address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
Phone Number

**NOTE: Authorized Representatives, Legal Guardians, and Powers of Attorney cannot also be the Member's paid caregiver(s) on the CD-PASS service option.**

## Representative's Acceptance of Responsibility

If an Authorized Representative has been designated, or any existing Powers of Attorney or Legal Guardianships were identified, that representative must complete the following:

I, \_\_\_\_\_, agree to the following:  
(NAME OF REPRESENTATIVE)

1. I will assist the Member with all employer responsibilities that they are unable or unwilling to perform, specifically all of the following: \_\_\_\_\_

2. I will serve as the Member's designated representative on CD-PASS.

3. I have read and understand the Self-Guided Orientation (DHS Pub # 10-02).

4. I understand that I cannot also serve as the Member's paid caregiver.

\_\_\_\_\_  
Authorized Representative Signature

\_\_\_\_\_  
Date

**NOTE: Member's signature is required on the following page. If appointing multiple representatives, complete page 2 for each.**

## Acknowledgement

I authorize the Oklahoma Department of Human Services (DHS) and its contracted agents to share my medical or social information with any individuals identified above. Pursuant to Oklahoma Statute, Title 63, Section 1-502(B), I have been advised that the information I authorize for release may include information that could be considered information about non-communicable or communicable diseases.

This authorization is in effect for one year from the original date of my signature. I understand that I may revoke, or amend, this authorization at any time.

## Signatures

\_\_\_\_\_  
Member or legal agent (POA/LG) signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Case manager signature  
(Not required on initial application by Member)

\_\_\_\_\_  
Date