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| DEPARTMENT OF HEALTH SERVICESDivision of Medicaid ServicesF-20987 (03/2017) | STATE OF WISCONSIN |
| AUTHORIZED REPRESENTATIVE DESIGNATIONMedicaid COMMUNITY WAIVER PROGRAMSIndividualized 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. |
|  | **SIGNATURE** – Recipient / Applicant |  | Today’s Date |  |
|  | **SIGNATURE** – Witness |  | Today’s Date |  |
|  | **SIGNATURE** – Witness |  | 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. |
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|  | **SIGNATURE** – Authorized Representative |  | Today’s Date |  |
|  | **SIGNATURE** – Witness |  | Today’s Date |  |