VendorFiscal/Employer Agenct (VF/EA)
Financial Management Services (FMS)

DESIGNATED REPRESENTATIVE FORM

Participant Information

Participant ID # _____ DOB_____/_____/_____

Last Name_____ First Name _____ M.I._____

Signature of Common Law Employer or Participant _____ Date _____

Designated Representative

Please circle either YES or NO which indicates your agreement with and acknowledgement of the following:

1. I understand that I may designate a family member or friend as a Designated Representative to assist me in my responsibilities to the extent that I prefer. My Designated Representative may not also act as my direct care worker. I understand that if I choose a Designated Representative, I am not giving up any of my decision-making authority. I understand that I may change my mind and revoke my Designated Representative at any time by notifying Public Partnerships, LLC my vendor fiscal employer agent.

2. I want to designate a Designated Representative to assist me in receiving self-directed services. I have discussed the specific assistance I would like from my Designated Representative. I give my permission for members of my PA DPWOLTL support team to contact my Designated Representative listed below:

If yes, provide the following information:

Last Name: _____ First Name: _____ M.I.: _____

Address: _____

City _____ State _____ Zip _____

Home Phone Number: ____/_____/_____ Cell Phone Number: ____/____/_____

E-mail Address: _____

I agree to serve as the Participant's Designated Representative.

Designated Representative Signature _____ Date _____

*Please note: This is an **OPTIONAL** form. This form is only required if an additional individual other than the Common Law Employer or Participant will be performing Employer responsibilities on behalf of the CLE/Participant.*