# Designation of Authorized Representative
# RI PersonalChoice Program

**Consumer Name** _____

**Address** _____

**City** _____ **State** _____ **Zip** _____

**Telephone #** _____ **Medical Assistance #** _____-_____-_____

**I Hereby Designate:**

**Name:** _____

**Address:** _____

**City:** _____ **State:** _____ **ZIP:** _____

**to serve as my representative in the RI PersonalChoice Program. My representative will complete and sign all forms and agree to meet all documentation requirements for this Program. My representative will assist me in using the RI PersonalChoice monthly allowance to purchase the services and items that meet my personal care needs as documented in my approved Individual Service and Spending Plan. My representative will assure that my independence and choices are honored and supported.**

_____ _____
**Consumer's Signature** **Date**

**I hereby agree to serve as the Representative for the above named Consumer and understand my responsibilities and duties under the RI PersonalChoice program.**

_____ _____
**Authorized Representatives Signature** **Date**

_____ _____
**Witness Signature** **Date**
**(Required if either the Consumer or Representative sign with a mark)**