

Representative Choice Form



I may use this form to choose:

- A client representative
- A consumer employer representative

Client

Client representative

I understand that I can appoint someone to help me make long-term care decisions. For example, a person I choose may help me decide where to live, who to use as my provider, and make decisions that will keep me safe. I would use this person if I want support or am no longer able to make decisions for myself.

Date comp.

Case number

I **do not** have to name anyone. If I do not choose someone and it is determined I can no longer make decisions for myself, APD will appoint a client representative for me. APD will use this priority order:

Prime number

- Guardian or other legal representative
- Spouse
- Majority of adult children
- Parent
- Majority of adult siblings
- Any adult relative or friend
- Advocacy agency or individual

Date of birth

SSN (*last 4*)

Branch code

Unless I give other instructions, APD will use the person I choose only if a doctor or other health professional determines that I am no longer able to make decisions.

Worker

No matter who I choose and how much I want them involved:

- If I disagree with my chosen decision-maker, APD will listen to me first.
- I have the right to contest decisions I disagree with my client representative makes on my behalf.
- APD will encourage and support me to be included whenever my client representative makes decisions on my behalf. I understand APD wants me in the driver's seat when it comes to planning my services.

Worker phone

I may revoke or change my chosen client representative(s) at any time.

I understand:

I **do not** have to choose a client representative. If I do not choose a client representative and my health or safety is at risk, APD may appoint one for me.

The use of a client representative:

- **Does not** mean I am incompetent
- **Does not** take away my legal and civil rights

I do not want to choose a client representative.

I do want a client representative, but cannot identify anyone at this time.

I will choose a client representative; see page 3.

Consumer employer representative

I understand that if I choose to receive in-home services provided by a homecare worker:

- I must be able to manage the employer duties listed below or
- I must choose someone to manage them for me

No one paid to provide me services can be my consumer employer representative. If it is determined that my consumer employer representative cannot perform the duties I must choose a new one.

Employer duties include:

- Locate, screen and hire a qualified homecare worker
- Supervise and train the homecare worker
- Schedule the homecare worker's work, leave and coverage
- Track the hours worked and verify the authorized hours completed by the homecare worker
- Recognize, discuss and try to correct any work problems with the homecare worker and
- Terminate an unsatisfactory homecare worker.

I understand that if I select a consumer employer representative, any decisions should still be made with me.

I choose to manage my own employer duties.

I choose to have a consumer employer representative; see page 4.

Client representative information

For future decision-making, I choose the following persons to make long-term care decisions for me if I am unable:

My first choice is:

Name: _____ (first, middle, last)
Date of birth: _____ Relationship to me: _____
Street address: _____
City, state, ZIP: _____
Phone number(s): _____ (specify type: cell, work, home)

My second choice is:

Name: _____ (first, middle, last)
Date of birth: _____ Relationship to me: _____
Street address: _____
City, state, ZIP: _____
Phone number(s): _____ (specify type: cell, work, home)

My third choice is:

Name: _____ (first, middle, last)
Date of birth: _____ Relationship to me: _____
Street address: _____
City, state, ZIP: _____
Phone number(s): _____ (specify type: cell, work, home)

Signature _____ Date _____

For APD office use only

No client representative identified. APD will appoint one if needed.

Consumer employer representative information

Name: _____ (first, middle, last)
Date of birth: _____ Relationship to me: _____
Street address: _____
City, state, ZIP: _____
Phone number(s): _____ (specify type: cell, work, home)

By signing below, I accept responsibility, on behalf of the client, for the consumer employment duties listed above under "consumer employer representative." If I cannot, or choose not to continue these duties, I will notify the person I have been helping and that person's case manager.

Signature of consumer employer representative, if any

Date

You can get this document in other languages, large print, braille or a format you prefer. Contact the APD forms coordinator at 503-945-6484 or email dhs.forms@state.or.us. We accept all relay calls or you can dial 711.