REPRESENTATIVE CHOICE FORM

DHS Oregon Department of Human Services

By using this form, I may choose the following types of Representatives: Client Representative and Consumer's Employer Representative.

Aging and People with Disabilities (APD)

CLIENT REPRESENTATIVE

I understand that I can appoint someone to help make Long-Term Care decisions for me. For example, they may help me decide where to live, who to choose as my provider, and make decisions that will help keep me safe. This person would be used when I want support with making decisions or am no longer able to make decisions for myself.

I **do not** have to name someone. If I do not choose anyone and it is determined I can no longer make decisions for myself, a decision-maker will be appointed for me. If needed, APD will appoint a decision-maker for me in this priority order:

- Guardian or other Legal Representative
- Spouse
- Majority of adult children
- Parent
- Majority of adult siblings
- Any adult relative or friend
- Advocacy Agency or Individual

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.

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 made on my behalf that I disagree with.
- APD will encourage and support me to be included when-ever decisions are being made about me. I understand APD wants me in the driver's seat when it comes to planning my services.

Client
[text]

Date comp.
[text]

Case number
[text]

Prime number
[text]

Date of birth
[text]

SSN (last 4)
[text]

Branch code
[text]

Worker
[text]

Worker phone
[text]

I may revoke or change my chosen Client Representative(s) at any time.

It has been explained to me that:

I **do not** have to choose a Client Representative. If I do not choose a Client Representative and my health or safety are at risk, one may be appointed 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 wish to have a Client Representative, but cannot identify anyone at this time.

☐ I will choose a Client Representative; see pages 3.

CONSUMER'S 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 Consumer's Employer Responsibilities explained below; or
- I must choose someone to manage them for me.

Anyone who is paid to provide me services cannot be my Employer Representative. If it is determined that my chosen Employer Representative cannot perform the Employer Responsibilities, a new one must be chosen.

Consumer's Employer Representatives 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 attempt to correct any performance deficiencies with the homecare worker; and
- Terminate an unsatisfactory homecare worker.

I understand that if I select an Employer Representative, that individual should discuss any decisions made with me.

☐ I choose to manage my own Employer Responsibilities.

☐ I choose to have a Consumer's Employer Representative; see page 4.

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CLIENT REPRESENTATIVE INFORMATION

For Future Decision-Making, I choose the following person(s) to make long-term care decisions for me if I am unable:

MY 1st CHOICE IS:

Name: _____ (first, middle, last)

Date of Birth: _____ Relationship to Consumer: _____

Street Address: _____

City, State, Zip Code: _____

Phone Number(s): _____ (specify type: cell, work, home)

MY 2nd CHOICE IS:

Name: _____ (first, middle, last)

Date of Birth: _____ Relationship to Consumer: _____

Street Address: _____

City, State, Zip Code: _____

Phone Number(s): _____ (specify type: cell, work, home)

MY 3rd CHOICE IS:

Name: _____ (first, middle, last)

Date of Birth: _____ Relationship to Consumer: _____

Street Address: _____

City, State, Zip Code: _____

Phone Number(s): _____ (specify type: cell, work, home)

Signature _____ Date_____

FOR APD OFFICE USE ONLY

☐ *The individual is unable to identify a Client Representative. APD will appoint one.*

CONSUMER'S EMPLOYER REPRESENTATIVE INFORMATION

Name: _____ (first, middle, last)

Date of Birth: _____ Relationship to Consumer: _____

Street Address: _____

City, State, Zip Code: _____

Phone Number(s): _____ (specify type: cell, work, home)

CONSUMER'S EMPLOYER REPRESENTATIVE

By signing below, I am confirming that I accept responsibility, on behalf of the Participant named above, for the Employment Responsibilities listed above under Employer Representative. If I am unable or chose to discontinue these responsibilities, I will notify the individual I have been assisting and the case manager so that someone else can be designated.

_____ _____

Signature of Consumer's 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 accepts all relay calls or you can dial 711.