

**Veteran Directed Home and Community Based Services
Enrollment Agreement / Authorized Representative**

Name of Participant: _____

I have reviewed that materials provided to me by my Service Coordinator that explain:

- the Veteran’s Directed Home & Community Based Services Program (VD-HCBS),
- my rights and responsibilities in directing my care,
- the role of the Service Coordinator, and
- the roles of the Western Montana Area VI Agency on Aging–ADRC and FMS.

I have decided to participate in this program.

_____ **I do not wish to designate a representative.**

_____ **I will designate a representative to work on my behalf.**

I hereby designate:

Name: _____ **Phone:** _____

Address: _____

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

to serve as my representative in the VD-HCBS Program. My representative will complete and sign all forms and agrees to meet all documentation requirements of this Program. My representative will use the VD-HCBS monthly allowance to purchase the services and items to meet my personal care need as listed on the Service and Support Plan budget and will assure that all items purchased and services received with the VD-HCBS monthly allowance are paid.

Participant’s Signature

Date

I hereby agree to serve as the representative for the above named participant and understand my responsibilities and duties under the VD-HCBS Program.

Authorized Representative’s Signature

Date