VENTURE FORTHE
PERSONALIZED HOME CARE SERVICES

Finger Lakes Office
75 Lafayette Ave.
Canandaigua, NY 14424
Phone 315-651-6970
Fax: 315-220-8044

Rochester Office
687 Lee Rd, Suite C-185
Rochester, NY 14606
Phone: 585-413-3752
Fax: 585-568-8310

Niagara Falls Office
3900 Packard Rd.
Niagara Falls, NY 14303
Phone 716-285-8070
Fax: 716-285-8250

Olean Office
242 North Union Street
Olean, NY 14760
Phone 716-376-9996
Fax: 716-379-8409

Jamestown Office
421 E. 2nd Street, Suite 2F
Jamestown, NY 14701
Phone: 716-870-8857
Fax: 716-483-1613

Authorized Representative Designation Form

You may submit this form if you would like to designate a representative to act on your behalf with respect to the Consumer Directed Personal Assistance Program (CDPAP) administered by Venture Forthe, Inc. (Venture Forthe). If an authorized representative signed your CDPAP documents for you or if you are an authorized representative acting on behalf of someone else, you MUST submit this form.

Note: An authorized representative has the authority to act on a participant's behalf in all matters with Venture Forthe and the CDPAP program and may receive personal information about the participant until we receive a cancellation notice terminating their authority.

You can choose someone to help you

You may choose an authorized representative to help you with the documentation required in the CDPAP program. **You are not required to have a representative in order to participate in the CDPAP program.**

Who can help me?

1. An authorized representative can be a friend, family member, relative, or other person of your choosing who agrees to help you. It is up to you to choose an authorized representative if you want one. You must designate in writing (fill out Section I, Part A) the person who you want to be your authorized representative. Your authorized representative must also fill out Section I, Part B.
2. If you are unable to designate an authorized representative in writing, a person who is acting responsibly on your behalf can be your authorized representative if that person certifies, by filling out Section II, that you are not able to provide a written designation, and that he or she is acting responsibly on your behalf.

What are the duties and responsibilities of a Designated Representative?

An authorized representative shall:

1. fill out and sign your CDPAP related forms, including but not limited to:
    a. Intake form;
    b. Consumer agreement; and
    c. Compliance Plan Acknowledgement.
2. complete and sign timesheets;
3. hire, fire, train, supervise, and schedule personal assistants;
4. give proof of information reported;
5. report changes in your address or other circumstances; and
6. act on your behalf in all matters with Venture Forthe and the CDPAP program.

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How does an authorized representative designation end?

If you decide that you no longer want a Section I or Section II authorized representative, you must notify Venture Forthe at the time you want the designation to end by doing one of the following:

- **Mailing** a letter notifying us that the designation has ended to:
  Venture Forthe, Inc.
  Attn: CDPAP
  3900 Packard Road
  Niagara Falls, NY 14303;

- **Faxing** a letter notifying us that the designation has ended to **716-285-8250**; or

- **Calling** us at **716-285-8070** to notify us that the designation has ended.

If you mail or fax this notice, you must include your name, address, date of birth, the name of your authorized representative, a statement that the designation has ended and your signature or, if you cannot provide written notice, the signature of someone acting on your behalf (in the case of a Section II authorized representative only).

In addition, if your authorized representative notifies us that he or she is no longer acting on your behalf, we will no longer recognize the person as your authorized representative.

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Section I Representative Designation

(Use if participant is able to sign)

Part A – To be filled out by participant. Please print, except for signature.

Participant's Name	Participant's date of birth (mm/dd/yyyy)
Participant's phone number ☐ Home ☐ Cell	Participant's e-mail address
Participant's address (mailing address, city, state, zip).	

I certify that I have chosen the following person to be the authorized representative for myself and I understand that this representative may sign on my behalf all documents related to the CDPAP program including timesheets; give proof of information reported on these forms; report to Venture Forthe changes in my address or other circumstances; and act on my behalf in all other matters with Venture Forthe and the CDPAP program.

Participant's signature Date

Authorized representative's name Authorized representatives phone number

Authorized representative's address (mailing address, city, state, zip)

Part B- To be filled out by authorized representative. Please print, except for signature.

I certify that I know enough about the applicant set forth above to take responsibility for the correctness of the statements made on his or her behalf during the CDPAP process and in all communication with Venture Forthe. I understand my duties and responsibilities as this person's authorized representative (explained on pg. 1 of this form) and which may include accurate reporting of time for services provided. I further certify that I will exercise this authority within the rules of the CDPAP program, the New York Medicaid Program, the Consumer Agreement, and all other applicable laws; and at all times maintain the confidentiality of any information regarding the participant set forth above that is provided to me by Venture Forthe.

Authorized representative's signature Date

Authorized representative's printed name Authorized representative's e-mail address

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Section II Representative Designation

(Use if participant is unable to provide written designation)

Part A- To be filled out by authorized representative. Please print, except for signature.

I certify that I know enough about the participant set forth below to take responsibility to the correctness of the statements made on his or her behalf during the eligibility process and in other communications with Venture Forthe. I understand my duties and responsibilities as this person's authorized representative (as explained on pg. 1 of this form and which may include accurate reporting of time for services provided) and that this person cannot provide written designation. I have told the person that he or she may remove or replace me as his or her authorized representative at any time by the methods described earlier in this form. I further certify that I will exercise this authority within the rules of the CDPAP program, the New York Medicaid Program, the Consumer Agreement, and all other applicable laws; and at all times maintain the confidentiality of any information regarding the participant set forth above that is provided to me by Venture Forthe.

Participant's Name

Participant's date of birth (mm/dd/yyyy)

Authorized representative's signature Date

Authorized representative's name (first, middle, last)

Authorized representative's address (mailing address, city, state, zip)

Authorized representative's email address Phone Number