AUTHORIZED REPRESENTATIVE AGREEMENT

Client Name	Client's CDWA ID

Instructions:
As the Client, you may want someone to help you manage your IP(s). This is usually a trusted family member or friend. Complete this form if you want to appoint someone to help with your responsibilities under the Consumer Directed Employer (CDE) program. Consumer Direct Care Network Washington (CDWA) will be able to discuss your care under the CDE program with the Authorized Representative. Appointing an authorized representative is a voluntary decision. You may cancel or change this at any time by contacting CDWA.

Authorized Representative Information:

First Name Middle Initial Last Name:	*Phone Number:* Landline_______________ Mobile_______________
Date of Birth:	*Social Security Number (optional):*
Gender: ☐ Male ☐ Female ☐ Undeclared	*Relationship to Client:*
Email:	*Preferred Language:*
Address City, State, Zip code:	

By signing below, I agree to be the Client's Authorized Representative. I understand CDWA may contact me regarding Client care, including IP hiring, time submission or employment issues or concerns. I agree to keep confidential any information about the Client or the IP(s) that I get from CDWA.

Signature of Authorized Representative: ____________________________________ **Date:** _______________

By signing below, I, the Client, appoint and allow the above-named person to act on my account as indicated.

Select One:
☐ I am adding this individual as a new Authorized Representative for me.
☐ I am removing my previous Authorized Representative(s). This individual will be my new Authorized Representative.

Signature of Client: ____ **Date:** _______________

Please submit by email or US Mail as shown below:
Email: CDWAForms@ConsumerDirectCare.com

Mail:
Consumer Direct Care Network Washington
3450 S 344th Way, Suite 200
Federal Way, WA 98001

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