Description of Duties of Representative

A Representative may be a family member, friend, income payee, or other person who willingly accepts responsibility for performing Employer of Record or Managing Employer tasks that the Employer is unable to perform. Representatives must show a personal commitment to the member, and must be willing to follow their wishes and respect their preferences while using sound judgment to act on their behalf. Representatives receive no monetary compensation, and may not serve as a service provider for the Member, with the exception of providing guardianship services. The Representative may not be known to have any history of physical, mental, or financial abuse, or to have been excluded from participation in the Medicare or Medicaid Programs. The Representative must also meet the following requirements:

- Demonstrate knowledge and understanding of the Member's needs and preferences, and respect those preferences
- Agree to a predetermined level of contact with the Member
- Is at least 18 years of age
- Is willing and able to comply with program requirements, including attending required training, and reading manuals/handbooks that describe program regulations
- Is approved by the Employer to act in this capacity

Specific duties of the Representative are:

- Work with the Employer, Care Coordinator, Financial Support Agency, and/or Community Navigator to assure that the Employer responsibilities are completed
- Make all or some of the decisions for the Employer, based on the Member's preferences, desires and abilities to make those decisions
- Manage, with the Employer, the Individual and Family Supports Budget, using it for services stated in the ISP
- Manage, with the Employer of Record, the Employer functions
- Maintain records as required.

NC Innovations Representative Screening Questionnaire

Name: _____ Record Number: _____

Name of Proposed Representative: _____

Mailing Address of Proposed Representative

Street Address: _____

City: _____ State: _____ ZIP: _____

Day Phone: _____ Evening Phone: _____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Please describe your relationship with the member, how long you have known the member and how often you have contact:

_____

_____

_____

☐ Yes ☐ No Do you receive money from, or are you dependent on, the member for support?

If Yes, please identify the amount of money or support you receive from the member and the reason you receive it.

_____

☐ Yes ☐ No Do you understand that you cannot pay yourself for this role and cannot become a paid caregiver for the member?

☐ Yes ☐ No Do you understand that you make decisions based on the desired preferences of the member and not your own desired preferences?

☐ Yes ☐ No **After reading the description that outlines the responsibilities of the Representative, do you understand your duties and are you willing to volunteer to serve as the member's Representative and comply with program requirements?**

☐ Yes ☐ No Are you willing to meet with the member and Employer at least monthly?

☐ Yes ☐ No Are you at least 18 years old?

☐ Yes ☐ No Do you have any history of physical, mental, or financial abuse of another member or their funds?

☐ Yes ☐ No Have you been excluded from participating as a provider of Medicaid Services, or have you been convicted of Medicare or Medicaid fraud?

☐ Yes ☐ No Individual and Family Directed Supports Training completed (or referral to training made)?

☐ Yes ☐ No Individual and Family Directed Supports Assessment completed (or scheduled)?

Care Coordinator: _____ Date: _____

cc: Utilization Management Department (submit with ISP/ISP Update requesting participant-directed service)
CI Clinical Docs
Employer (Employer of Record or Managing Employer)
Representative