APPENDIX C

IFDS Designation of Representative Form

Member name: _____

Member's LRP(s) (if applicable): _____

Member record number: _____ Representative type: ☐ Voluntary ☐ Mandatory

IFDS option: ☐ Employer of Record ☐ Agency with Choice

Employer of Record/Managing Employer: _____

Prospective Representative: _____

I hereby designate _____ to serve as my Representative in the Individual and Family Directed Services (IFDS) option of the NC Innovations Waiver. I understand that I will remain the Employer and retain the status and any liability associated with my role as Employer. I understand that my appointment of a Representative is subject to approval by Vaya Health.

(Initial next to each of the following that apply.)

_____ My Representative will complete and sign all forms and send information to Vaya Health as required.

_____ My Representative has completed the initial orientation and initial self-direction training through a Community Navigator agency.

_____ I understand my Representative receives no monetary compensation for acting as my Representative.

_____ I may revoke this appointment at any time by notifying my care manager/care coordinator.

_____ I understand that if Vaya Health determines a different Representative is needed and there is not an approved Representative to self-direct services ready to step in the place and stead of the current Representative at the time of their removal or withdrawal, the member may be immediately transitioned to provider-managed services until a qualified Representative is identified and approved.

(Only initial next to the one that applies.)

_____My Representative will direct all self-directed services on the care plan and assume all Employer of Record/Managing Employer duties.

_____My Representative will assume only those duties I have designated in the IFDS Agreement.

Employer of Record/Managing Employer's signature	Date signed
Witness signature	Date signed

cc: Employer of Record/Managing Employer
Representative
Care manager/care coordinator (receives original)
Vaya UM Team (with care plan update requesting approval of self-directed service)
Member's AHR