



Authorized Representative Form

Individual's Six-Digit DDD ID Number: _____
Individual's First Name: _____
Individual's Last Name: _____

This form is required if the individual wishes to designate an Authorized Representative to speak to Public Partnerships on behalf of the individual, if/when necessary, and to:

1. Manage some or all Employer of Record responsibilities on the individual's behalf
AND/OR
2. Approve and sign all payment request forms submitted to Public Partnerships

An Authorized Representative must:

- Be at least 18 years of age
- Act in the best interest of the individual
- Respect the individual's preferences
- Maintain regular contact with the individual
- Be willing and able to meet and uphold all program requirements on behalf of the individual

An Authorized Representative cannot be:

- A self-directed employee who is working/providing services for the individual
- A vendor of services for the individual

Authorized Representative First Name:
Authorized Representative Last Name:
Authorized Representative Address (include city, state, zip code):
Authorized Representative Phone:
Authorized Representative Email:

Signature of Individual or Legal Guardian Date

Signature of Authorized Representative Date

If the individual's **Legal Guardian** is signing this form on behalf of the individual, please provide a copy of the guardianship order. If the individual's **Legal Guardian** is signing this form on behalf of the individual, and will also be the Authorized Representative, please sign both lines.

**Submit this Authorized Representative Form to Public Partnerships:
Email: njddd@pcgus.com | Fax: 1-844-561-5978**