

Participant-Directed Services  
**Designated Representative**  
**Revocation of Appointment/Reassignment of Responsibilities**

Participant's Name	Medicaid Number
Designated Representative's Name	
Relationship to Participant Receiving Services: <input type="checkbox"/> Self <input type="checkbox"/> Court-Appointed Guardian <input type="checkbox"/> Parent of a Minor <input type="checkbox"/> Durable Power of Attorney <input type="checkbox"/> Other: _____	

All Responsibilities Assumed by Participant

I, \_\_\_\_\_, will fulfill all responsibilities **without** the use of a designated representative. This revocation of the use of a designated representative is effective this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

**Participant:**

Printed Name \_\_\_\_\_

Participant Cannot Sign

Signature \_\_\_\_\_

Date \_\_\_\_\_

**Witness (required):**

Printed Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

*Identify by what authority witness has been given power to sign on behalf of the Participant:*

\_\_\_\_\_.

Identification of Responsibilities Retained by Designated Representative

I, \_\_\_\_\_, will fulfill some responsibilities **without** the use of a designated representative.

The following responsibilities shall be performed by the Participant:

\_\_\_\_\_.

\_\_\_\_\_.

\_\_\_\_\_.

The following responsibilities shall be continue to be performed by the Designated Representative:

\_\_\_\_\_.

\_\_\_\_\_.

\_\_\_\_\_.

This revocation of the use of a designated representative and/or reassignment of responsibilities is effective this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

**Participant:**

Printed Name \_\_\_\_\_

Participant Cannot Sign

Signature \_\_\_\_\_

Date \_\_\_\_\_

**Witness (required):**

Printed Name \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

*Identify by what authority witness has been given power to sign on behalf of the Participant:*

\_\_\_\_\_.