CONSUMER DIRECTED IN-HOME SUPPORTS

Completion of the following indicates interest in directing in-home supports for yourself or for the consumer you represent in the performance of nutritional and environmental support functions, non-medical personal care functions, and health maintenance tasks. This assistance is viewed as providing supports necessary in maintaining yourself or the consumer represented in the community rather than an institution and to carry out other functions of daily living, self-care and mobility, including those functions included in the definition of in-home supports and as outlined in the consumer's person centered plan.

If health maintenance activities are to be performed by in-home support staff an Authorizing Statement (CBS-102) form from the attending physician or licensed professional nurse my be completed and on file with your case manager indicating approval for directed in-home supports by yourself or your representative.

Indicate in the section below the level of involvement you or your representative wish to assume:

(Check one for each statement)		*Perform Independently*	*Request Assistance*
1.	Recruit and select in-home support staff	☐	☐
2.	Refer in-home support staff to appropriate agency for payroll registration	☐	☐
3.	Pre-screen applicants	☐	☐
4.	Perform direct supervision of in-home support staff	☐	☐
5.	Assign and schedule in-home support staff	☐	☐
6.	Complete periodic evaluation of in-home support staff	☐	☐
7.	Dismiss in-home support staff and provide back-up when necessary	☐	☐
8.	Maintain records of work performed and time sheets	☐	☐
9.	Communicate necessary information to payroll agent	☐	☐

10. If you have indicated *request assistance*, please describe or tell us who or how the assistance will be provided to accomplish these activities. This description should be dated and attached to this form.

My signature below indicates I am making application to direct my own care or designate someone to act on my behalf. I understand this is an application for services and is not an approval. Furthermore, I understand I can only apply to direct my own care or have someone act on my behalf one time per application year. Should I not choose to continue this option at any time I am required to give 10 days notice of my decision to the Community Developmental Disability Organization (CDDO).

_____ _____
Consumer Signature Date

_____ _____
Signature of Persons Acting on Consumer's Behalf Date

CONSUMER DIRECTED IN-HOME SUPPORTS

Consumer:_____ Social Security #:_____

Indicate the numbered activities the consumer has requested assistance with and describe how the assistance will be provided to accomplish these activities:

Activity Number	Description of assistance
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____

Consumer Date

_____ _____

Signature of Person(s) acting on Consumer's Behalf Date