

**INDIVIDUAL DIRECTED IN-HOME SUPPORTS**

Completion of the following indicates interest in directing in-home supports for yourself or the individual 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 individual 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 individual's person centered plan.

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 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 must be completed and on file with your case manager indicating approval for directed in-home supports by yourself or your representative.

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

(Check one for each statement)	<i>Perform Independently</i>	<i>Request Assistance</i>
1. <u>Recruit</u> and <u>select</u> in-home support staff	_____	_____
2. <u>Refer</u> in-home support staff to appropriate agency for payroll registration	_____	_____
3. <u>Pre-screen</u> 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 <i>request assistance</i> , 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).

\_\_\_\_\_  
 Individual Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Signature of Persons Acting on Individual's Behalf

\_\_\_\_\_  
 Date