Developmental Pathways
Dedicated to Individuals with Disabilities

Request for an Authorized Representative
(As defined in Section 25.5-10-202 (1.3) C.R.S.)

I authorize (Name): _____ to act as my representative in matters pertaining to my services and supports provided to me through Developmental Pathways. I understand that I may revoke this authorization at any time either verbally or in writing. This authorization is limited to one year from the date of the signatures below. Items initialed and checked below are included in this authorization:

_____Invitations to meetings: *(check all that apply):* ☐Annual Service Plan
☐ IDT Meetings
☐ IDT Meetings- only upon request

_____Copies of documents: *(check all that apply):* ☐Service Plans
☐IDT Meeting summaries
☐Other documents- only upon request

_____Copies of Incident Reports

_____Communication between my Authorized Representative and my Case Manager
(No third-party documents may be copied. Only the originator of the document has authority to release those documents. Developmental Pathways will provide information on how to obtain third party documents.)

I would like my Authorized Representative to keep what I say, and my personal information confidential and not share the information with anyone unless I give permission. I understand that while the above-named person has been designated as my Authorized Representative, they may not always agree with me, this does not change my role or rights regarding my input and choices in planning my services and supports and changes to the extent it is possible for me to participate. This also means that I keep my right to make choices and decisions.

_____
Name of Individual in services and DOB

_____ _____
Signature of Individual/Guardian Name (printed) Date

_____ _____
Signature Case Manager Name (printed) Date

Acceptance of Authorized Representative Role

I accept the designation to act as Authorized Representative in the manner described above for one year. I understand this authorization may be revoked at any time, verbally or in writing, by the person requesting I be their Authorized Representative.

_____ _____
Signature of Authorized Representative Name (printed) Date

_____ _____
Signature of Case Manager Name (printed) Date