



## WIL VETERAN IN CHARGE AUTHORIZED REPRESENTATIVE FORM

Veteran Name: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

### I. Authorized Representative Designation (check ONLY one box):

- I designate \_\_\_\_\_ to serve as my Authorized Representative for the Veteran in Charge (VIC) Program.
- My legal guardian, \_\_\_\_\_ (legal guardian), designates \_\_\_\_\_ to serve as Authorized Representative for the Veteran in Charge (VIC) Program.
- The person granted power of attorney for me, \_\_\_\_\_ (Power of Attorney), designates \_\_\_\_\_ to serve as Authorized Representative for the Veteran in Charge (VIC) Program.

### II. Authorized Representative Information:

Name: \_\_\_\_\_

Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Email Address: \_\_\_\_\_

Relationship to Veteran: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

### III. Authorized Representative Record Agreement:

I, \_\_\_\_\_ (full name) agree to serve as the Authorized Representative on behalf of \_\_\_\_\_ who is a participant in the Veteran in Charge (VIC) Program.

#### Requirements for Authorized Representative:

1. I am at least 18 years of age.
2. I know the participant very well.
3. I understand the kinds of care s/he needs and how s/he wants care to be given.
4. I know the participant's schedule and routine.
5. I know the participant's health care needs and the medicine s/he takes.
6. I am willing and able to do all of the things that are required to be the Authorized Representative for this VIC Program participant.
7. I will be present in the participant's home often enough to properly supervise staff. This usually means at least part of every employee's shift.
8. I understand that I will be the Authorized Representative for the employees who will provide care for this participant—they will work for me (instead of the Veteran). I understand this means that I will be responsible for most of the things that any other employer would do including training, supervision and termination of services.
9. I understand I will need to provide Premier Financial Management Services my Social Security number and will complete all federal Authorized Representative forms.

10. I understand that I cannot be paid to be the Authorized Representative.
11. I understand that I cannot be a paid employee in the VIC Program if I serve as the Authorized Representative.

**Tasks completed in partnership with the VIC participant:**

1. Find, interview and hire employees to provide care.
2. Define employees' job duties.
3. Develop a job description for employees.
4. Train employees to deliver care based on the participant's needs and preferences.
5. Set the schedule at which employees will give care.
6. Make sure employees work only as many hours as stated on the Veteran's Services Plan.
7. Supervise and evaluate employees' job performance.
8. Address problems or concerns with employees' performance.
9. Terminate an employee when needed.
10. Decide how much employees will be paid (within limits set by the State).
11. Review the time employees report to be sure it is correct.
12. Develop a back-up plan to address times that a scheduled employee doesn't report for their shift (the participant's health and safety must be assured).
13. Activate the back-up plan when needed to be sure the participant doesn't go without needed care.

I willingly accept **all** of the responsibilities of serving in this role. I understand that I will receive help from Wyoming Independent Living and Premier Financial Management Services in serving as an employer in the VIC Program.

1. My local WIL Advisor will work with me on recruitment and hiring strategies and review the employer packet with the Veteran.
2. My local WIL Advisor will provide information on home care agencies for emergency back-up plans.
3. Premier Financial Management Services will assist me and the employees I employ fill out employer/employee paperwork. They will pay the employees for the care they give and they will file the payroll tax forms that I must fill out as an employer.
4. Premier Financial Management Services can't help me supervise employees. I understand that I must do this for myself.

By signing below, I affirm that I have read and understood my responsibilities and agree to perform all of the responsibilities of a representative as defined above. I also, affirm that any questions or concerns that I have with the Authorized Representative form have been answered to my satisfaction by the WIL Advisor or Premier Financial Management Services.

Veteran Signature: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_\_\_

Legal Guardian/POA Signature (if applicable): \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_\_\_

Authorized Representative Signature: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_\_\_