Kansas Department for Aging
and Disability Services

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:<br>☐ Self ☐ Court-Appointed Guardian ☐ Parent of a Minor ☐ Durable Power of Attorney<br>☐ 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:*

_____.