Limited Power of Attorney for WA Cares Fund Benefits

Beneficiary Name
WA Cares ID Number (if known)

What is a Limited Power of Attorney for WA Cares Fund Benefits?

WA Cares Fund is the Long-Term Services and Supports Trust Program established under chapter 50B.04 RCW. The Limited Power of Attorney for WA Cares Fund Benefits form is a legal document that allows someone you choose to act on your behalf and make decisions about your WA Cares benefits, as administered under chapter 50B.04 RCW, including decisions made with the Department of Social and Health Services and the Employment Security Department. In a power of attorney agreement, the principal is the individual who grants the power of attorney, while the person receiving that power is called the agent or attorney in fact. This form will be shared with the Employment Security Department.

Do I need to complete the Limited Power of Attorney for WA Cares Fund Benefits form?

You are not required to have a power of attorney. You are not required to use this form to execute a power of attorney agreement. Completing this form is optional and may be revoked at any time.

What if I already have a power of attorney?

If you already have a power of attorney, you can review that document to determine if it gives your agent the authority to act on your behalf and make decisions about your WA Cares benefits. If so, you may provide a copy to WA Cares. WA Cares must have a copy on file for your agent or attorney in fact to manage your benefits on your behalf.

What if I have questions about executing a power of attorney?

Disclaimer: WA Cares staff cannot offer legal advice or answer questions about how to complete this form. If you have questions about whether to execute a power of attorney agreement or how to do so, you should consult an attorney.

Additional information and legal resources are available through the Northwest Justice Project.

Website: www.nwjustice.org **Phone:** 1-888-201-1012

Submit this form:

Upload: You may upload completed forms to your online WA Cares account.

Mail to:
DSHS
The WA Cares Fund
PO Box 45612
Olympia, WA 98504-5612

Contact WA Cares for additional information:

Call: 844-CARE4WA (1-844-227-3492)

Visit: www.wacaresfund.wa.gov

Needed to execute this POA:

To execute the form in accordance with: RCW 11.125.050.

- Your full name
- Two witnesses or a notary

Information WA Cares will need:

- Your street address
- Your phone number
- Your WA Cares ID number (if known)
- Agent's legal name and contact information

Language assistance is available:

- Language interpreter services
- Sign Language Services
- Braille
- TTY/TDD users dial 1-800-833-6384

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Limited Power of Attorney

For _____, _____:

1. **Agent.** I choose _____, as my agent with authority to manage my WA Cares Fund benefits. The authority granted by this document to the above-named individual is limited to decisions about my WA Cares Fund benefits and not other government benefits.
2. **Alternate (optional).** If the agent named above is unable or unwilling to act, I choose _____, as my agent with authority to manage WA Cares Fund benefits.
3. **My Rights.** I keep all rights to make decisions for myself about my WA Cares Fund benefits, regardless of whether this power of attorney is in effect, until I no longer have the capacity to do so.
4. **Revocation.** I revoke any other Limited Power of Attorney for WA Cares Fund benefits that I have signed in the past. I may revoke this power of attorney at any time.
5. **Powers.** My Agent shall have full power and authority to manage my WA Cares Fund benefits as fully and effectively as I could do myself, including, but not limited to, the power to:
   a) Enroll in, apply for, select, reject, change, amend, or discontinue benefits;
   b) Prepare, file, and maintain a claim of the principal for WA Cares Fund benefits;
   c) Initiate, participate in, submit to alternative dispute resolution, settle, oppose, or propose or accept a compromise with respect to litigation concerning any WA Cares Fund benefits the principal may be entitled to receive under chapter 50B.04 RCW.
6. **HIPAA Release.** I authorize the WA Cares Fund to release all information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that is relevant to the management of my WA Cares benefit, to my Agent.
7. **Start Date.** This power of attorney is effective on the day I sign it.
8. **End Date.** This power of attorney will end if I revoke it or when I die.
9. **Durable (optional).** ☐ By checking this box, I certify that I want my Agent to use this power of attorney to manage my affairs even if I become sick, injured, or incapacitated, and that my disability will not affect this power of attorney.

I have read and understand the above information.

My signature (in front of a notary or two witnesses): Date Signed

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Statement of Witnesses

Witness 1

On _____, _____, signed this limited power of attorney for WA Care Fund benefits in my presence. I agreed to witness their signature at their request. I am not related to this person by blood, marriage, or state registered domestic partnership. I do not provide care for this person at home or in a long-term care facility.

Signature	Printed Name of Witness 1
Address	Phone Number (with area code)

Witness 2

On _____, _____, signed this limited power of attorney for WA Care Fund benefits in my presence. I agreed to witness their signature at their request. I am not related to this person by blood, marriage, or state registered domestic partnership. I do not provide care for this person at home or in a long-term care facility.

Signature	Printed Name of Witness 2
Address	Phone Number (with area code)

Certificate of Acknowledgement (completed by a Notary Public)

State of _____

County of _____

Signed before me on _____ by _____.

_____
Signature of Notary Public

_____
Commission Expiration Date

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Attachment: Contact Information

This contact information is not required to execute a Power of Attorney agreement but is needed by WA Cares. Provide as much information as you are able.

WA Cares beneficiary contact information

Full Name	Phone Number	WA Care ID Number
Street Address	City	State Zip Code
Mailing Address	City	State Zip Code

Agent contact information

Full Name	Phone Number
Street Address	City State Zip Code
Mailing Address	City State Zip Code

Alternate Agent contact information (if chosen)

Full Name	Phone Number
Street Address	City State Zip Code
Mailing Address	City State Zip Code

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