AUTHORIZED REPRESENTATIVE DECLARATION

You may choose an authorized representative to help you with some or all of the requirements of applying for or getting benefits. These benefits include: cash, medical, Food Stamps, and/or Child Care assistance.

An authorized representative is a friend, relative or other person who has a concern for your well-being. An authorized representative is a person you choose. We will not choose one for you. The person you choose must agree to help you. An agency cannot act as an authorized representative, but an individual at an agency can. An authorized representative must be an individual person.

An authorized representative may go to interviews for you. They may fill out an application form and other paperwork for you. They may also report changes in your income, resources, and other changes for you. They may receive your Electronic Benefits Transfer (EBT) card, medical assistance ID card, and other mail from us. You get to choose what you would like them to do for you or on your behalf by checking the boxes below.

AUTHORIZED REPRESENTATIVE DUTIES

Check off the things that you want the authorized representative to do for you:

☐ Get my application, forms and other Department paperwork, and fill these forms out for me.

☐ Provide the Department with proof of my income, resources, and other case information, and report and verify changes in my case circumstances to the Department for me.

☐ Receive my notices from the Department.

☐ Receive my EBT Card in their name.

☐ Receive my EBT Card for me.

☐ Receive my medical assistance ID card for me.

☐ Receive my cash benefits for me.

☐ Go to my eligibility interviews for me.

☐ Other: _____

CLIENT'S SIGNATURE

Please read the following statements carefully. Your signature below means you have read, understand, and accept these statements.

- **I certify** that I have read and understand the information on this form.
- **I understand** that I am responsible for any errors, omissions, or inaccurate information that my authorized representative reports to the District Office.
- **I understand** that if my authorized representative uses my benefits without my permission, these benefits will not be replaced or reissued by the Department of Health and Human Services.
- **I understand** that the person I named as my authorized representative will continue to act for me unless I tell the Department in writing of a change.

_____ _____

Client's Signature Date

_____

Client's **Printed** Name

(Please Turn Over)

AUTHORIZED REPRESENTATIVE INFORMATION

Tell us your authorized representative's name, address, and telephone number. Please print clearly.

First Name | Middle Initial | Last Name

Street/Mailing Address | Telephone Number

City, State, and Zip Code | Alternate Telephone Number

Date of Birth (Optional) | Describe your relationship to the authorized representative. (If your authorized representative is a member of an agency, write the name of the agency here.)

AUTHORIZED REPRESENTATIVE'S SIGNATURE

I certify that I have read and understand the information on this form. I agree to accept the duties noted on this form and understand the following:

- **I understand** that I must give proof of my identity to act as an Authorized Representative.
- **I understand** that if I have been disqualified for a program violation, I cannot act as an Authorized Representative unless there is no one else suitable to represent this individual.
- **I understand** that the Department has the authority to discontinue my ability to act as an Authorized Representative if it is determined that I am not acting in the best interest of the household I am assisting.
- **I understand** that if I am an Authorized Representative for a Food Stamp recipient in a drug and alcohol treatment center or other group living arrangement, and I give erroneous information which leads to an over-issuance of benefits, those benefits will be recouped from the treatment center or group living arrangement group, not just the resident I represent.

Authorized Representative's Signature | Date

Authorized Representative's **Printed** Name