AUTHORIZED REPRESENTATIVE DECLARATION

You may choose an authorized representative to help you with some or all of the responsibilities of applying for or receiving financial and/or medical assistance and/or food stamp benefits.

An authorized representative is a friend, relative or other person who has a concern for your well-being and who agrees to help you. An authorized representative is a person you choose. We will not choose an authorized representative for you.

An authorized representative may attend interviews, and fill out an application form and other Department of Health and Human Services paperwork for you. An authorized representative may also report changes in your income, resources, and other changes to the Department, and may receive your Electronic Benefits Transfer (EBT) card, medical assistance ID card, and mail from us.

AUTHORIZED REPRESENTATIVE INFORMATION

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

(Name)	(Street/Mailing Address)
(Telephone Number)	(City, State, and Zip Code)

Describe your relationship to the authorized representative. _____

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 the verification 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 of Health and Human Services.
- ☐ Receive my cash benefits for me.
- ☐ Receive my food stamp benefits for me.
- ☐ Pick up my EBT Card for me.
- ☐ Pick up my EBT Card and activate it for me.
- ☐ Receive my medical assistance ID card for me.
- ☐ Go to my eligibility interviews for me.
- ☐ Other _____

(Please Turn Over)

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 _____

AUTHORIZED REPRESENTATIVE'S SIGNATURE

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

Authorized Representative's Signature _____ Date _____

Authorized Representative's **Printed** Name _____