

**ARIZONA DEPARTMENT
OF ECONOMIC SECURITY
Family Assistance
Administration**

**AUTHORIZED
REPRESENTATIVE
REMOVAL**

Nutrition Assistance

Cash Assistance

Medical Assistance

Tuberculosis Control

**Case Name (*Last, First,
M.I.*):**

**See pages 9-10 for USDA/EOE/
ADA/LEP/GINA disclosures**

Case Number

HEAplus app ID:

Date: _____

You can remove a person as your Authorized Representative at any time. Removing a person's permission to be your Authorized Representative does NOT affect any action taken or information provided

**by the Authorized Representative while the Authorized Representative had permission to act on your behalf.
REMOVE AUTHORIZED REPRESENTATIVE**

I want to remove the person identified below as my Authorized Representative. I understand that this person will no longer be able to:

- **Complete my application, forms and other Department paperwork for me.**
- **Attend eligibility interviews and conduct telephone eligibility interviews for me.**
- **Provide my proof of income, resources and other case information, and report and verify changes in my case circumstances for**

me.

- **Receive my notices and other mail from the Department for me.**
- **Get any of my case information from the Department.**

**AUTHORIZED
REPRESENTATIVE
INFORMATION**

Person's Name (*Last, First, M.I.*):

**Person's Mailing Address
(No., Street):**

City: _____

State: _____

ZIP Code: _____

**Person's Phone Number
(Include area code):**

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 reported to the Department of Economic Security**

while the Authorized Representative had permission to act on my behalf.

- **I understand that I must notify the Department of Economic Security, in writing, if I need to appoint a new Authorized Representative.**

Client's Signature:

Date: _____

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