Arizona Department of Economic Security Family Assistance Administration

Authorized Representative Request

- ☐ Cash Assistance (CA)
- ☐ Nutrition Assistance (NA)
- ☐ Medical Assistance (MA)
- ☐ Tuberculosis Control (TC)

See pages 26-30 for USDA/ EOE/ADA disclosures

Case Name:

Case No.:

HEAplus App ID:

Date:

An Authorized Representative is a friend, relative, or other person who knows your circumstances and can assist you in the application process. An Authorized Representative is someone you choose;

Case Name:

Case No.:

FAA does not choose for you. The person you choose must be willing to help you. An agency cannot act as an authorized representative, but an individual at an agency can. This individual will be able to assist you in the following ways:

- **Complete and sign your application,**

Case Name:

Case No.:

forms, and other Department paperwork for you.

- **Complete eligibility interviews in person or on the phone for you.**
- **Provide your proof of income, resources, and other case information to DES and/or AHCCCS.**
- **Report and verify**

Case Name:

Case No.:

changes in your case circumstances for you (address, income, resources, expenses, etc.).

- Receive your notices and other mail from

Authorized Representative Information

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

Case Name:

Case No.:

(MA only) Is the representative acting on behalf of an organization? ☐ Yes ☐ No

Name of the Organization:

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

☐ Home ☐ Cell
☐ Message ☐ Work

Case Name:

Case No.:

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

City:

State:

ZIP Code:

My Authorized Representative's preferred language is:

Spoken: ☐ English

Case Name:

Case No.: _____

☐ Spanish ☐ Other:

Written: ☐ English

☐ Spanish ☐ Other:

This person is known to me as *(Your relationship to this person)*:

Case Name:

Case No.:

This Section Must Be Completed When Requesting A Nutrition Assistance (NA) Authorized Representative

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

Case Name:

Case No.:

Applicant:

I understand that if my NA Authorized Representative is currently disqualified from NA for an intentional program violation (IPV), they cannot act as an NA Authorized Representative. (When this happens, check one of the following boxes):

Case Name:

Case No.:

☐ I will select another person to serve as my NA Authorized Representative.

☐ This is the only person that is available to be my NA Authorized Representative.

Signature of Applicant:

Date:

Case Name:

Case No.:

Authorized Representative:

I understand that if I am currently disqualified from NA for an intentional program violation (IPV), I cannot act as an NA Authorized Representative unless there is no one else suitable to represent this individual.

Please provide your date

Case Name:

_____

Case No.: _____

of birth _____ and check one of the following boxes: *(this is the NA Authorized Representative's date of birth)*

☐ **I am currently serving a disqualification for a NA IPV.**

☐ **I am not currently serving a disqualification for a NA IPV.**

Case Name:

Case No.:

Signature of Representative:

Date:

When a legal guardian has been appointed for the adult only applicant in the household, the applicant's signature is not required for the legal guardian to be appointed

Case Name:

Case No.:

as an authorized representative.
Only the authorized representative's signature is needed.

Authorized Representative Authorization

Please read carefully. Your signature below means you have read, understand, and accept

Case Name:

Case No.:

these statements.

Applicant:

By signing below, I (the customer) give permission for the person listed on the previous page to act on my behalf as my representative. That person is allowed to help me in the process of qualifying for help with Medical

Case Name:

_____

Case No.: _____

and Medicare costs, Nutrition Assistance, Cash Assistance, and/ or Tuberculosis Control. I do give permission and agree that my representative may do all of the following on my behalf:

- **Complete and sign my application.**
- **Provide any documents requested,**

Case Name:

Case No.:

including my personal information.

- **Sign on my behalf to permit other people, businesses, or agencies to give personal information about me to DES and/or AHCCCS, including protected health information needed to determine if I have a disability.**

Case Name:

Case No.:

I also agree to give information about my personal circumstances to my representative and agree to allow my representative to assign all my rights to medical reimbursement claims to AHCCCS on my behalf.

Authorized Representative:

By signing below, I (the representative) agree

Case Name:

_____

Case No.: _____

to act on the customer's behalf. I also agree to:

- **Provide only truthful and complete information under the penalty of perjury.**
- **Fill in and sign needed forms.**
- **Obtain and give DES and/or AHCCCS all information needed to determine if the customer can**

Case Name:

Case No.:

qualify for help with Medical insurance and Medicare costs, Nutrition Assistance, Cash Assistance, and/or Tuberculosis Control, such as Social Security number, income, assets, citizenship, residency, medical insurance, and information about the customer's spouse, minor

Case Name:

Case No.:

children, and parents (if the customer is a minor parent).

- **Tell DES and/or AHCCCS right away if the customer has an/a:**
  - **Increase or decrease in income;**
  - **Increase or decrease in assets;**
  - **Change in ownership of assets, including**

Case Name:

Case No.:

opening or closing financial accounts;

- **Changes in address; or**
- **Change in health insurance or the amount of premiums paid.**

- **Maintain confidentiality of any information regarding the applicant or beneficiary provided by the agency.**

Case Name:

Case No.:

If I am determined eligible, this authorization will stay in effect until I or my representative tells you to stop it. This authorization will expire when my application for assistance is withdrawn or denied, or when my eligibility ends. However, this authorization will continue during any time

Case Name:

Case No.:

while I am contesting my eligibility in an administrative hearing or court proceeding.

Signature of Applicant:

Date:

Signature of Representative:

Date:

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than

English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should

complete a Form AD-3027, USDA Program Discrimination Complaint Form which can be obtained online at https://www.usda.gov/sites/default/files/documents/ad-3027.pdf, from any USDA office, by calling (833) 620-1071, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR)

about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to:

1. **mail:**
   Food and Nutrition Service, USDA
   1320 Braddock Place, Room 334
   Alexandria, VA 22314; or
2. **fax:**
   (833) 256-1665 or (202) 690-7442; or
3. **email:**
   FNSCIVILRIGHTSCOMPLAINTS@usda.gov

This institution is an equal opportunity provider.

To request this document in alternative format or for further information about this policy, contact your local office; TTY/ TDD Services: 7-1-1. • Disponible en español en línea o en la oficina local.