ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Family Assistance Administration

NUTRITION ASSISTANCE (NA) AUTHORIZED REPRESENTATIVE REQUEST

Case Name _____

Case Number _____

You may choose an Authorized Representative, an adult non-household member, to help you with the requirements of applying for or getting benefits. 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,

See page 9 for USDA/EOE/ADA disclosures

but an individual at the agency can act as your representative. This individual will be able to assist you in the following ways:

- **Complete your application, forms, and other department paperwork for you.**
- **Complete eligibility interviews in person or on the telephone for you.**
- **Provide your proof of income, resources, and other case information.**
- **Report and verify changes in your case circumstances for you.**
- **Receive your notices and other mail from the department for you.**

AUTHORIZED REPRESENTATIVE INFORMATION

I want the person named below as my Authorized Representative:

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

Person's Phone Number *(include area code)* _____

☐ **Home** ☐ **Cell** ☐ **Message** ☐ **Work**

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

City _____

State _____ **ZIP Code** _____

My Authorized Representative's preferred language is:

Spoken: ☐ **English** ☐ **Spanish**

☐ **Other:** _____

Written: ☐ **English** ☐ **Spanish**

☐ **Other:** _____

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

_____

AUTHORIZED REPRESENTATIVE AUTHORIZATION

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

Applicant:
I certify that I have read and understand the information on this form. **I certify that the person I chose to be my Authorized Representative is an adult who is sufficiently aware of my family's financial and other household circumstances to give any information required by the Department of Economic Security.** **I understand that if my NA Authorized Representative is currently serving an NA intentional program violation (IPV):**

☐ **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.**

I understand that I am responsible for any incorrect information given by my representative.

I understand that I may be fined, prosecuted, or imprisoned for any program fraud committed by my representative.

I understand that the person I named as my Authorized Representative will continue to act for me until I revoke, in writing, permission to represent me.

Authorized Representative:

I certify that I have read and understand the information on this form.

I agree to accept the duties on this form.

I understand that I must give proof of my identity to act as an Authorized Representative.

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

Please provide your date of birth _____ and check one of the following boxes:

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

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

I understand that the Department of Economic Security (DES) 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 I may be held personally liable if it is found that I, as an Authorized Representative, am responsible for causing an overpayment to the household that I represent.

I understand that I will be required to update my information with the Department of Economic Security (DES) each time the household I assist applies for a renewal of Nutrition Assistance (NA) benefits.

If I am determined eligible, this NA 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 while I am contesting my eligibility in an administrative hearing or court proceeding.

Applicant's Signature: _____

Date: _____

Authorized Representative's Signature: _____

Date: _____

The USDA is an equal opportunity provider and employer • DES/TANF Agencies are Equal Opportunity Employers/Programs • Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Title II of the Genetic Information Nondiscrimination Act (GINA) of 2008; the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, disability, genetics and retaliation. To request this document in alternative format or for further information about this policy, contact your local office; TTY/TDD Services: 7-1-1. • Free language assistance for DES services is available upon request. • Disponible en español en línea o en la oficina local