ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Family Assistance Administration

NUTRITION ASSISTANCE AUTHORIZED REPRESENTATIVE REMOVAL

CASE NAME *(Last, First, M.I.)*

_____

CASE NO.

_____

DATE _____

See pages 9-12 for USDA/EOE/ ADA/LEP/GINA disclosures

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 PHONE NUMBER *(Include area code)*

PERSON'S MAILING ADDRESS *(No., Street, City, State, ZIP 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 _____

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. The Department must make a reasonable accommodation to allow a person with a disability to take part in a program, service or activity. For example, this means if necessary, the Department must provide sign language interpreters for people who are deaf,

a wheelchair accessible location, or enlarged print materials. It also means that the Department will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible.

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.