

**Arizona Department
of Economic Security
Family Assistance
Administration**

**Nutrition Assistance
(NA) Authorized
Representative Request
Case Name:**

Case Number:

**See pages 19-24
for USDA/EOE/ADA
disclosures**

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; 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 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.

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 (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.

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

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
Nutrition Assistance.**

**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, including my personal information.**
- **Sign on my behalf to permit other people, businesses, or agencies to give**

personal information about me to DES including protected health information needed to determine if I have a disability.

I also agree to give information about my personal circumstances to my representative.

Authorized Representative:

By signing below, I (*the representative*) agree 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 all information needed for Nutrition Assistance, such as Social Security number, income, assets, citizenship, residency, medical insurance, and information about the customer's spouse,**

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

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

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: _____

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:
**[FNSCIVILRIGHTS
COMPLAINTS@
usda.gov](mailto:FNSCIVILRIGHTS.COMPLAINTS@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.