ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Family Assistance Administration

AUTHORIZED REPRESENTATIVE REQUEST

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

Case Name: _____ Case Number: _____

HEAplus App ID: _____ Date: _____

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 another 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, but an individual at an agency can. This individual will be able to assist you in the following ways:

- Complete and sign your application, 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 changes in your case circumstances for you (address, income, resources, expenses, etc.).
- Receive your notices and other mail from the department for you.

AUTHORIZED REPRESENTATIVE INFORMATION

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

(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

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)*: _____

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.

Applicant:	Authorized Representative:
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): ☐ 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 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 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.
Signature of Applicant: Date:	Signature of Representative: Date:

See page 3 for USDA/EOE/ADA disclosures

AUTHORIZED REPRESENTATIVE AUTHORIZATION

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

<table>
<tr><td>Applicant:</td><td>Authorized Representative:</td></tr>
<tr><td>By signing below, I (the customer) give permission listed above to act as my representative:
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 I am responsible for any incorrect information given by my representative and may be prosecuted for fraud and be fined and/or imprisonment.
I understand that the person I named as my Authorized Representative will continue to act for me until I revoke, in writing, the Authorized Representative's permission to represent me.
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 am disabled.
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.</td><td>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 penalty of perjury.
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 agree to tell DES and/or AHCCCS about changes in the household's circumstances.
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 DES each time the household I assist applies for a renewal of benefits.
Maintain the confidentiality of any information regarding the applicant or beneficiary provided by the agency.</td></tr>
<tr><td colspan="2">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 while I am contesting my eligibility in an administrative hearing or court proceeding.</td></tr>
<tr><td>Signature of Applicant: Date:</td><td>Signature of Representative: Date:</td></tr>
</table>

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.