Arizona Department of Economic Security
Family Assistance Administration

# Authorized Representative Removal

☐ Nutrition Assistance ☐ Cash Assistance ☐ Medical Assistance ☐ Tuberculosis Control

Case Name *(Last, First, M.I.)*: _____ Case Number: _____

HEAplus App ID: _____ Date: _____

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 Mailing Address *(No., Street)*: _____

City: _____ State: _____ ZIP Code: _____

Person's Phone Number *(Include area 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.

If you are completing this form electronically, typing your signature will constitute a valid signature.

Client's Signature: _____ Date: _____

See reverse for USDA/EOE/ADA disclosures

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Persons with disabilities who require alternative means of communication for program information (e.g., braille, large print, audiotape, American Sign Language) should contact the responsible State or local Agency that administers the program or contact USDA through the Telecommunications Relay Service at 711 ( voice and TTY). Additionally, Program information may be made available in languages other than English.

To file a program discrimination complaint, complete the USDA Program Discrimination Complaint Form, AD-3027, found online at How to File a Program Discrimination Complaint and at any USDA office or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

1. **Mail:**
   Food and Nutrition Service
   1320 Braddock Place, Room 334
   Alexandria, VA 22314; or
2. **Email:**
   FNSCIVILRIGHTSCOMPLAINTS@usda.gov

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