

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
 Family Assistance Administration

**NUTRITION ASSISTANCE
 AUTHORIZED REPRESENTATIVE REQUEST**

CASE NAME <i>(Last, First, M.I.)</i>	CASE NO.	DATE
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You may choose an Authorized Representative 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, but an individual at an agency can. An Authorized Representative must be a person that does not live with you. An Authorized Representative may go to interviews for you. They may fill out an application form and other paperwork for you. They may also report changes in your income, resources or other changes for you.

AUTHORIZED REPRESENTATIVE

- I want the person identified below as my **Authorized Representative**. I understand that this person will 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.

AUTHORIZED REPRESENTATIVE INFORMATION

PERSON'S NAME <i>(Last, First, M.I.)</i>	PERSON'S PHONE NUMBER <i>(Include area code)</i>
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PERSON'S MAILING ADDRESS *(No., Street, City, State, ZIP Code)*

THIS PERSON IS KNOWN TO ME AS *(Your relationship to this person)*

THE REASON I OR MY SPOUSE CANNOT BE INTERVIEWED IS

Continue to page 2 – Both you and your authorized representative must sign this form.

CASE NAME (Last, First, M.I.)	CASE NO.
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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 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 Nutrition Assistance Program.
- **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 sent to jail.
- **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.

CLIENT’S SIGNATURE	DATE
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AUTHORIZED REPRESENTATIVE’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 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 have been disqualified from Nutrition Assistance for an intentional program violation, I cannot act as an Authorized Representative unless there is no one else suitable to represent this individual.
- **I understand** that the Department of Economic Security 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 each time the household I assist applies for a renewal of Nutrition Assistance benefits.

AUTHORIZED REPRESENTATIVE’S SIGNATURE	AUTHORIZED REPRESENTATIVE’S PRINTED NAME	DATE
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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.