

**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.

**See pages 13-15 for
USDA/EOE/ADA disclosures**

Case Name: _____

Case Number: _____

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.**

Case Name: _____

Case Number: _____

- **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*): _____

Case Name: _____

Case Number: _____

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*):**

Case Name: _____

Case Number: _____

**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:

**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.**

Case Name: _____

Case Number: _____

This is the only person that is available to be my NA Authorized Representative.

Signature of Applicant:

Date: _____

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)*

Case Name: _____

Case Number: _____

**I am currently serving a
disqualification for a NA IPV.**

**I am not currently serving a
disqualification for a NA IPV.**

Signature of Representative:

Date: _____

AUTHORIZED REPRESENTATIVE AUTHORIZATION

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

Applicant:

**By signing below, I (the customer)
give permission listed above to act as
my representative:**

Case Name: _____

Case Number: _____

- **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.**

Case Name: _____

Case Number: _____

- **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.

Authorized Representative:

By signing below, I (the representative) agree to act on the customer's behalf. I also agree to:

Case Name: _____

Case Number: _____

- **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.**

Case Name: _____

Case Number: _____

- **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.**
-

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.

Case Name: _____

Case Number: _____

Signature of Applicant:

Date: _____

Signature of Representative:

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:

**[FNSCIVILRIGHTSCOMPLAINTS@
usda.gov](mailto: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
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7-1-1. • Disponible en español en
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