

AUTHORIZED REPRESENTATIVE (AR) DECLARATION

You may choose an Authorized Representative (AR) to help you with some or all of the steps needed to apply for or get benefits. These benefits include: cash, medical, Food Stamps, and/or Child Care assistance.

An AR is a friend, family member, or other adult who has a concern for your well-being. An AR is an adult you choose. We will not choose one for you. The person you choose must agree to help you. An agency cannot act as an AR, but a person working at an agency can. An AR must be an individual person.

An AR may go to eligibility interviews for you. An AR may fill out an application form and other paperwork for you. An AR may also report changes in your income, resources, and other changes for you. The AR may get your Electronic Benefits Transfer (EBT) card, medical assistance ID card, and other mail from us. The AR may ask for an Administrative Appeal for you if you are not satisfied with any eligibility decision made by DHHS. The AR may also represent you at an Administrative Appeal. You get to choose what you would like the AR to do for you by checking the boxes below.

AUTHORIZED REPRESENTATIVE DUTIES

Please check off the things that you want the AR to do for you:

- Get my application, forms, and other DHHS paperwork for me.
- Fill out my application, forms, and other DHHS paperwork for me.
- Give DHHS proof of my income, resources, and other case information, and report and verify changes in my case circumstances to DHHS for me.
- Get my notices from DHHS. Get my cash benefits for me.
- Go to my eligibility interviews for me.
- Access my EBT Account. *This means my AR and I will each get an EBT Card in our own name. We will both be able to use these EBT cards to get my benefits.*
- Ask for an Administrative Appeal for me. Represent me at an Appeal if I decide I want one.
- Talk to my managed care organization (MCO) or qualified health plan (QHP) for me.
- Get my medical assistance ID card for me. Other: _____

CLIENT'S SIGNATURE

Please read the following statements carefully. Your signature below means you have read, understand, and agree to 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 AR reports to DHHS.
- **I understand** that if my AR uses my benefits without my permission, these benefits will not be replaced by DHHS.
- **I understand** that the person I named as my AR will continue to act for me until I or my AR tells DHHS of a change. However, if I am living at a drug and alcohol treatment center or am part of another group living arrangement and my AR is an individual employed by that agency, I understand that in accordance with 7 CFR 273.11(f)(5)(ii), that individual will automatically no longer be my AR once I leave the treatment center.

Client's **Printed** Name

Date

Client's Signature

Date of Birth

MID #

Case #

(Please Turn Over)

AUTHORIZED REPRESENTATIVE INFORMATION

Please tell us your AR's name, address, and telephone number. Please print clearly.

First Name

Middle Initial

Last Name

Street/Mailing Address

Telephone Number

City, State, and Zip Code

Alternate Telephone Number

Date of Birth
(Optional)

Describe your relationship to the AR
(If your AR is a member of an agency, write the name of the agency here.)

AUTHORIZED REPRESENTATIVE'S SIGNATURE

My signature below means that I have read and understand the information on this form. I agree to accept the duties noted on this form and understand and agree to the following:

- **I understand** that I must give proof of my identity to act as an AR.
- **I understand** that if I have been disqualified for a program violation, I cannot act as an AR unless there is no one else suitable to represent this individual.
- **I understand** that if I am an AR for a Food Stamp recipient in a drug and alcohol treatment center or other group living arrangement, and I give erroneous information which leads to the resident I represent getting too many benefits, those benefits will be recouped from the treatment center or group living arrangement group, not just the resident I represent, and the center will be reported to USDA SNAP licensing per 7 CFR 273.11(e)(7).
- **I agree** to act as an AR for the client noted on the front side of this form until I or the client tells DHHS of a change.

Authorized Representative's **Printed** Name

Date

Authorized Representative's Signature

Return to: Centralized Scanning Unit (CSU), P.O. Box 181, Concord, NH 03301