

AUTHORIZED REPRESENTATIVE (AR) DECLARATION

You may choose an Authorized Representative (AR) to help you apply for or get benefits. You must fill out this form for every AR you choose.

An AR is a friend, family member, other adult, or an agency that has a concern for your wellbeing. You must choose your own AR. Your AR must agree to help you.

DHHS will talk to your AR until you or your AR tells us otherwise.

AUTHORIZED REPRESENTATIVE DUTIES

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

- Get, fill out, and sign applications, forms, and other DHHS paperwork for me.
- Get a copy of all my notices from DHHS.
- Go to my eligibility interviews for me.
- Get an EBT card with my AR's name on it. (I will still get my own EBT Card. My AR and I will both be able to call EBT Customer Service.) My AR's EBT card will access my SNAP and/or Cash.

OR

- Talk to EBT Customer Service for me. (I will be the only one to get an EBT Card.)
- Request and represent me at an Administrative Appeal.
- Talk to my managed care organization (MCO) or qualified health plan (QHP) 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 authorize** my AR to perform the duties checked on this form until I or my AR tells DHHS of a change.
- **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 if I am living at a drug and alcohol treatment center or am part of another group living arrangement and my AR is that agency, in accordance with 7 CFR 273.11(f)(5)(ii), that agency will automatically no longer be my AR once I leave.

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. If your AR is an Agency, please tell us the name of a contact person in that agency. 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
(Must be 18 or older)

Describe your relationship to your AR
(If your AR is 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 agree** to represent the client, as described on this form, until I or the client tells DHHS of a change.
- **I agree** to give proof of my identity to act as an AR.
- **I certify** that I am concerned for the client's wellbeing.
- **I certify** that I am knowledgeable about the client's circumstances or can get more information.
- **I certify** that if I am signing for an agency, I have the authority to do so.
- **I agree** to protect confidential information in accordance with state and federal law.
- For clients applying for or receiving Medicaid if I am acting for an agency **the agency agrees to:**
 - Safeguard information about the client; (42 CFR 431.300 et. seq.) and
 - Keep the client's tax information confidential; (45 CFR 155.260(f))
- If I am acting on behalf of a Medicaid provider **the provider agrees** not to reassign Medicaid claims except as allowed by 42 CFR 447.10.
- **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 SNAP 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).

Authorized Representative's **Printed** Name

Date

Authorized Representative's Signature

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

NONDISCRIMINATION STATEMENT

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:

mail:
Food and Nutrition Service, USDA
1320 Braddock Place, Room 334
Alexandria, VA 22314; or

fax:
(833) 256-1665 or (202) 690-7442; or

email:
FNCSIVILRIGHTSCOMPLAINTS@usda.gov

This institution is an equal opportunity provider.