



Section 1

If you want someone to act on your behalf in applying for benefits and/or act for you on an ongoing basis, this form must be completed. Be sure to select the function(s) that the representative is being authorized to do. You can select more than one representative and choose the same or different functions. The representative may be an individual or an organization. Complete ONE form per authorized representative. Both you and your representative must sign and date this form.

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Nam	Name of Representative (Please print clearly)									
				Check asso	ociation with applicant/r	ecipie	nt. Pleas	se select (ONE <i>(1)</i> .	
	Attorney			Eligibility Ass	sistance Company		Friend			Family
	Institution	n of Residence		Waiver Case I	Manager		Other (5	Specify):		
Maili	ng Address	(number and street,	city, st	ate, and ZIP co	ode)					
					SE	SELECT THE FUNCTION(S) THE AUTHORIZED REPRESENTATIVE WILL DO:				
FU	FUNCTION FUNCTION DESCRIPTION						HEALTH COVERAGE			
F	Sign application and be interviewed. Provide all required proof of information necessary to determine eligibility for benefits. Receive the Notice of the application decision. Speak on applicant's behalf at a hearing if the application decision is appealed.						Apply			
ON	NGOING	Report changes. Attend periodic redeterminations.						Ongoing		
In agreeing to be the authorized representative, I understand that I am expected to be knowledgeable of the applicant's/recipient's circumstances and that this authorization can be revoked by the applicant/recipient at any time. I agree to maintain or be legally bound to maintain the confidentiality of any information regarding the applicant/recipient provided by the Division of Family Resources.										
Signa	ture						Da	ate (<i>mm/dd</i>	d/yyyy)	Telephone ((###) ###-####)
Section 3										
I authorize this representative to act for me in taking care of the functions and program eligibility process which I have checked above. (If applicant/recipient is medically incapable to sign authorization, provide medical documentation.) I understand that I am responsible for the information anyone acting as my authorized representative gives, including any information that may be incorrect. I also understand that if at any time I wish to stop the person(s) I chose from being my authorized representative, it is my responsibility to contact the Division of Family Resources.										
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Case	Number (<i>Op</i>	ptional)			Applicant/Recipient Date	e of Bir	irth (<i>mm/dd/yyyy</i>) Applicant		Applicant/Reciir	pient Social Security Number
				XXX-XX-						