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|  | | | MISSOURI DEPARTMENT OF SOCIAL SERVICES  FAMILY SUPPORT DIVISION  **FOOD STAMP APPOINTMENT OF A FACILITY AS AN AUTHORIZED REPRESENTATIVE** | | | | | | | | | | | | | |
|  | If you are a resident of a Drug and Alcohol treatment and rehabilitation program and you want to apply for Food Stamps, you must appoint an authorized representative who is employed by the treatment facility to apply and access benefits on your behalf.  If you are resident of a group living arrangement and are able to apply for Food Stamp benefits on your own, you do not need to sign this form to apply for or receive Food Stamp benefits. You may contact the Family Support Division (FSD) on your own to apply for benefits, complete your mid-certification review, or conduct other business; or you may appoint an authorized representative to represent you, as provided by 7 CFR 273.2(n)(4).  To appoint an authorized representative, you must complete this form and the person you appoint to be your authorized representative must acknowledge and accept the appointment. **Even if you have an authorized representative, the FSD may communicate directly with you when the division determines it is appropriate.** | | | | | | | | | | | | | | |  |
|  | I, |  | | | | | | | TELEPHONE: |  | | | | | |  |
|  | ADDRESS: | | |  | | | | | | | | | | | |  |
|  | DCN or SSN: | | | |  | | | | | | | | | | |  |
|  | **hereby appoint**: | | | | | | | | | | | | | | |  |
|  | FACILITY: | | | | | TELEPHONE: | | | | | | | | | |  |
|  | **to act as my authorized representative.** | | | | | | | | | | | | | | |  |
|  | The appointed facility will act with a responsibility and obligation to me for the following purpose: | | | | | | | | | | | | | | |  |
|  | COMPLETE APPLICATION/REVIEWS and/or  ACCESS BENEFITS | | | | | | | | | | | | | | |  |
|  | **The facility I have appointed has knowledge of my circumstances necessary to complete an application, mid-certification review or act on my behalf and shall not willfully make a false statement, misrepresentation, conceal information, or fail to report any fact or event required to be reported by any law, regulation or rule of this State or the United States.**  **I understand that if I apply on my own behalf, I am responsible for the action or inaction of my representative on my behalf and for the information provided by my authorized representative, including any information that may be incorrect.** | | | | | | | | | | | | | | |  |
|  | APPLICANT/PARTICIPANT SIGNATURE | | | | | | | | | | DATE | | | | |  |
|  |  | | | | | | | | | |  | |  | | |  |
|  |  | | | | | | | | | |  | | | | |  |
|  | **Acknowledgement and Acceptance of Appointment of Authorized Representative:** | | | | | | | | | | | | | | |  |
|  | I, acting on behalf of the named facility, | | | | | | |  | | | | PHONE: | | |  |  |
|  | FACILTY NAME/ADDRESS: | | | | | |  | | | | | | | | |  |
|  | EMAIL ADDRESS: | | | | |  | | | | | | | | | |  |
|  | ***I represent the facility named above. I have provided proof of my identity to the FSD.*** I have knowledge of the applicant/participant’s circumstances necessary to complete an application, mid-certification review and/or access Food Stamp benefits on their behalf. I shall not willfully make a false statement, misrepresentation, conceal information, or fail to report any fact or event required to be reported by any law, regulation or rule of this State or the United States. I will report changes to FSD on behalf of the customer. This includes changes in income or other household circumstances. I will inform the local FSD office if I am no longer the authorized representative. I must do the following once I cease being an authorized representative:   * Immediately stop using the EBT card. Do not access any more benefits. * Notify FSD of the change in authorized representative status within 48 hours.   By signing this form, I understand the above responsibilities. As authorized representative I am responsible for any misrepresentation or intentional program violation which I knowingly commit. I hereby accept this appointment of authorized representative for the duration and purpose stated on this form. ***The authorized representative is not required to sign this form in order to be an authorized representative.*** | | | | | | | | | | | | | | |  |
|  | AUTHORIZED REPRESENTATIVE SIGNATURE ***(OPTIONAL)*** | | | | | | | | | | DATE | | | | |  |
|  |  | | | | | | | | | |  | | |  | |  |
| *This appointment will remain in effect until the FSD receives notice the authorization has been revoked by the applicant or participant or the authorized representative.* | | | | | | | | | | | | | | | | |

**FS-6ARF Facility INSTRUCTIONS**

**FOOD STAMP APPOINTMENT OF A FACILITY AUTHORIZED REPRESENTATIVE**

(Food Stamp Program)

**Purpose:** This form is required to provide a signed statement for an applicant/participant designating a facility to be their authorized representative to apply for the Food Stamp program on behalf of an applicant/participant, to assist the participant with the mid-certification review process or a specific agency action, and/or access Food Stamp benefits on a participant’s behalf.

This form does not authorize a facility access to protected health information that may be contained in a record with the Family Support Division. If applicant/participant wishes to have protected health information released to their authorized representative, they must request this release and disclosure of information by completing the Department of Social Services HIPAA compliant release form [650-2616 (HIPPA) Authorization of Disclosure of Consumer Medical/Health Information](file:///G:\Terri).

The authorized representative must be an individual person at least eighteen (18) years of age and employed by the facility.

**Number of Copies and Distribution**: This form is available in hard copy or PDF. The original is completed by the applicant/participant and a representative from the facility appointed as authorized representative, and is filed as a permanent part of the record. The facility appointed as authorized representative may request or keep a copy for their records.

**Instructions for Completion of Authorized Representative appointment**: The Appointment of Authorized Representative section of the form is completed by the applicant/participant.

The **applicant/participant must** complete the form as follows:

* print their name, telephone number, address, and DCN or SSN in the first four blanks.
* print the name/facility of the individual they are appointing to be their representative.
* complete the purpose of authorized representative; indicate the purpose for which they are appointing an authorized representative by checking Complete Application/Review and/or Access Benefits.
* sign and date; the applicant/participant must sign to appoint the named Authorized Representative.

The **individual representing the facility and appointed as authorized representative must** complete the form as follows:

* print their name and the facility’s name, telephone number, address and DCN or DVN in the first four blanks.
* provide verification of identity.
* a signature is not required, but encouraged.

**Duration of Appointment**: The authorization will remain in effect until:

* The FSD receives notice the authorization has been revoked by the applicant or participant or the authorized representative.
* The FSD receives notice that the applicant or participant is deceased.