MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

APPOINTING AN AUTHORIZED REPRESENTATIVE

Use this form if you would like an authorized representative to help you apply for MO HealthNet coverage, Temporary Assistance, Food Stamps, and/or act on your behalf if you get MO HealthNet coverage, Temporary Assistance, and/or Food Stamps.
If you are a resident of a Drug and Alcohol treatment and rehabilitation program and you want to apply for Food Stamp benefits, you must appoint an authorized representative who is employed by the treatment facility to apply and access benefits for you.
If you reside in a group home and are eligible for Food Stamp benefits on your own, you do not need to sign this form to apply for or receive Food Stamp benefits.
You can choose to have an authorized representative or you can act on your own behalf. If you already have a guardian, conservator, or attorney-in-fact appointed by a valid Power of Attorney under Missouri law, they must appoint an authorized representative for you. Even if you choose to have an authorized representative, the FSD may sometimes need to contact you directly.

Instructions:
1. Fill out and sign your name(s) in Sections 1 and 2. Only one (1) form is necessary if the same authorized representative is being appointed for both members of a married couple.
2. Have the person, facility, or organization you're appointing fill out and sign their name in Section 3 to verify they accept the responsibilities listed below.
3. Return your completed form to the FSD **within 30 days** of the date(s) you and your authorized representative sign and date the form.

SECTION 1: YOUR INFORMATION AND AUTHORIZATION TO BE REPRESENTED

YOUR NAME(S)	TELEPHONE NUMBER

ADDRESS

DATE OF BIRTH OR DCN (CASE NUMBER)

I APPOINT AS MY/OUR AUTHORIZED REPRESENTATIVE:

NAME

NOTE: By appointing an authorized representative, you are consenting to allow the FSD to send letters and notices to your authorized representative.

For MO HealthNet and Food Stamps, I/we authorize this person or organization to be responsible for (check one or more boxes):
- ❑ Helping me/us apply for MO HealthNet coverage
- ❑ Helping me/us apply for Food Stamp benefits
- ❑ Acting on my/our behalf if I/we get MO HealthNet coverage, including annual reviews, and reporting changes
- ❑ Acting on my/our behalf if I/we get Food Stamp benefits, including mid-certification reviews, and reporting changes.

If your authorized representative helps you apply, your authorization will last until the FSD makes a final decision on your application, or you can end it sooner if you tell the FSD in writing.
If your authorized representative acts on your behalf, your authorization will last until you end it by writing to the FSD.

For Temporary Assistance, I/we authorize this person to be responsible for (check one or more boxes):
- ❑ Helping me/us apply for Temporary Assistance benefits
- ❑ Acting on my/our behalf if I/we get Temporary Assistance benefits, including annual reviews, and reporting changes

The person or organization I/we have appointed is age 18 or older and knows my/our situation well enough that they can complete my/our application or act on my/our behalf. They will not knowingly make a false or misleading statement, hide information, or fail to report any fact or event that is required to be reported by any law, regulation or rule of this State or the United States.

NOTE: Organizations may not be appointed for Temporary Assistance applicants or recipients.

I/we understand that I/we am responsible for the information given by my/our authorized representative, including any information that may be incorrect.

YOUR (APPLICANT/PARTICIPANT) SIGNATURE	DATE
YOUR SPOUSE'S SIGNATURE	

SECTION 2: YOUR AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION AND OTHER INFORMATION (MO HEALTHNET ONLY)

Please write your name and the name of a person who can receive protected health information and other information about you. Write the name of a person, not an organization.

I/We, (your name(s))_____ _____,
request and authorize Family Support Division to disclose information to this person:

(REPRESENTATIVE'S NAME)

Because I'm/we're giving this request and authorization, the FSD may release to the person named above:

- Requests for information
- Eligibility notices and medical information about this application
- My/our annual review
- Letters about agency action

This authorization will continue during the final decision on my/our application, my/our annual review, or agency action for which I/we gave this authorization. If I/we want to end my authorization sooner, I/we must tell the FSD in writing before the final application, annual review, or agency action decision.

I/we understand that the FSD is not responsible for what happens to information they release because I/we have requested and authorized them to disclose my/our Protected Health Information. I/we understand and agree that the FSD has given me/us a signed copy of this form.

YOUR (APPLICANT/PARTICIPANT) SIGNATURE	DATE
YOUR SPOUSE'S SIGNATURE	

SECTION 3: AUTHORIZED REPRESENTATIVE AGREEMENT AND ACCEPTANCE

Individual acting as Authorized Representative: Please fill out and sign this section.

REPRESENTATIVE'S NAME	TELEPHONE NUMBER
REPRESENTATIVE'S ADDRESS	
REPRESENTATIVE'S DATE OF BIRTH (TEMPORARY ASSISTANCE)	

I am age 18 or older and know the applicant's situation well enough to complete their application or act on their behalf. I will not knowingly make a false or misleading statement, hide information, or fail to report any fact or event that is required to be reported by any law, regulation or rule of this State or the United States.

I agree to be the applicant's authorized representative for the reason and length of time stated above. I will protect the privacy of any information I get while acting as authorized representative as required by Federal, State and local laws, regulations, ordinances, and directives about privacy.

AUTHORIZED REPRESENTATIVE'S SIGNATURE	DATE

Individual acting as authorized representative due to affiliation with an organization or facility: Please fill out and sign this section.

ORGANIZATION OR FACILITY NAME

ORGANIZATION OR FACILITY ADDRESS

ORGANIZATION OR FACILITY E-MAIL

ORGANIZATION OR FACILITY TELEPHONE

I represent the organization or facility named above. I have provided proof of my identity to the Family Support Division. I have knowledge of the applicant's or participant's situation well enough to complete their application or act on their behalf. I will not knowingly make a false or misleading statement, hide information, or fail to report any fact or event that is required to be reported by any law, regulation, or rule of this State or the United States.

I will report changes to the FSD on behalf of the participant as needed. I will inform the FSD if I am no longer an authorized representative.

I understand I must do the following once I stop being an authorized representative:

- Immediately stop using the EBT card.
- Notify the FSD of the change in authorized representative status within 48 hours.

I agree to be the applicants authorized representative. I will protect the privacy of any information I get while acting as an authorized representative as required by Federal, State, and local laws, regulations, and directives about privacy.

AUTHORIZED REPRESENTATIVE'S SIGNATURE	DATE

Need Help?

- By Phone: **1-855-FSD-INFO (1-855-373-4636)**
- Online: **mydss.mo.gov**
- In person: **Visit any FSD Office.** To find an office in your area, call the number above or visit us online.