



An authorized representative is an adult, or an organization, who the participant gave permission to act their behalf by applying for, obtaining, or using program benefits.

This authorized representative appointment continues until it is terminated by the participant or the representative in writing, the date of the participant's death, or as specified on the designation form.

Participants can use this form to end an authorized representative appointment. They must complete and sign this form.

Authorized Representative Revocation

Participant's Name

First Name	Middle Name	Last Name	Suffix
DCN	Social Security Number	Date of Birth	

I revoke my previous appointment of:

Representative's First Name	Middle Name	Last Name	Suffix
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Organization's Name (if any)

I understand that Family Support Division will no longer recognize this individual or organization as my authorized representative or allow them to act in an authorized representative capacity upon receipt of this signed and dated revocation request.

If submitting electronically – I have agreed to submit this form by electronic means. I understand that an electronic signature has the same legal effect and can be enforced in the same way as a written signature. I agree

Participant Signature:	Date:
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Return Information

Upload your document: Visit mydssupload.mo.gov to upload a copy of your document

Mail to: Family Support Division
 PO BOX 2700
 Jefferson City, MO 65102

Fax to: 573-526-9400