MISSOURI DEPARTMENT OF SOCIAL SERVICES

FAMILY SUPPORT DIVISION

APPOINTING AN AUTHORIZED REPRESENTATIVE

Fill out this form if you want to name someone or an organization to help you apply for MO HealthNet (MHN), Temporary Assistance (TA), Supplemental Nutrition Assistance Program (SNAP), or act on your behalf after you are approved. Family Support Division (FSD) calls this person an authorized representative.

If you have a guardian or conservator, they must be the ones to choose an authorized representative for you. If you have an attorney-in-fact appointed by a valid Power of Attorney under Missouri law, they can choose an authorized representative for you, or you can choose one yourself.

If you have other legal documents, like a court order for a guardian or a power of attorney, you can send in those documents instead of using this form.

If you have a spouse, both you and your spouse can name the same authorized representative. You can do this by listing both of your names in Section 1 and both of you signing in Section 2.

If both names are not listed and both signatures are not included, the authorized representative will ONLY be for the person whose name is listed and who signed.

Ways to return this form:

Upload:

Mydssupload.mo.gov

Mail:

Family Support Division

PO Box 2700

Jefferson City, MO 65102

In Person:

Find an office:

dss.mo.gov/offices.htm

Fax:

573-526-9400

For SNAP:

- If you are a resident of a Drug and Alcohol treatment and rehabilitation program and you want to apply for SNAP, 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 SNAP on your own, you do not need to sign this form to apply for or receive SNAP.

Instructions:

- Section 1: Fill out your information. If this is for a disabled child or someone with a guardian, this will be the applicant’s information.
- Section 2: Review and sign your name(s).
- Section 3: Have the person you choose fill out and sign their name to show they accept the responsibility.
- Return the completed form to FSD within 90 days of the date(s) you and your authorized representative sign and date the form. Return information is above.

If you are a Veteran in the state of Missouri and are interested in learning more about benefits and resources available to you and your dependents, visit: https://mvc.dps.mo.gov/MoVeteransInformation/Survey/DSS

Or scan the QR code:

Section 1: Your information
Your Legal Name (Please enter this name and date of birth or Department Client Number (DCN) at the top of each page.)
First
Middle
Last
Suffix
Date of birth

Social Security Number (optional)
DCN (if known)
Email address
Phone number
Your Spouse's or Second Parent's Legal Name (if they will be represented by the authorized representative)
First
Middle
Last
Suffix
Date of birth
Social Security Number (optional)
DCN (if known)

Email address
Phone number
Your Physical Address
Street Address
Apartment, Ste, or Trailer Number
City
State
Zip
Your Mailing Address (if different than above)
PO Box or Street Address
Apartment, Ste, or Trailer Number
City
State
Zip

Section 2: Your authorization to be represented
I/We appoint as my/our authorized representative:
First
Middle
Last
Suffix
OR Organization or Facility Name (if applicable)
For SNAP, I/we authorize this person or organization to be responsible to (check one or more boxes): ☐ Help me/us apply for SNAP benefits, including Mid-certification reviews, report changes, and receive notices. ☐ Access my benefits and receive an EBT card. ☐ Access FSD account online communications. ☐ Access FSD account online communications after I die.

For TA, I/we authorize this person (organizations may not be appointed as authorized representatives) to be responsible to (check one or more boxes):

- ☐ Help me/us apply for TA benefits, which includes acting on my/our behalf if I/we are approved for TA benefits, including annual reviews, report changes, and receive notices.
- ☐ Access FSD account online communications.
- ☐ Access FSD account online communications after I die.

For MHN, I/we authorize this person or organization to be responsible to (check one or more boxes):

- ☐ Help me/us apply for MO HealthNet coverage.
- ☐ Act on my behalf if I/we get MO HealthNet, including annual renewals and reporting changes.
- ☐ Access FSD account online communications.
- ☐ Access FSD account online communications after I die.

OR

☐ Sign and submit an MHN application on my behalf. This authorization ends after the application is submitted and this person has no other authority to act on my behalf. This person is not allowed to receive protected health information from DSS and or correspondence from FSD.

Note: If you select this box, any other MHN boxes checked will be rejected as this only allows your authorized representative to submit an application.

Section 3: Your agreement to be represented

Based on your selections on pages 7-9, your authorized representative may receive notices and forms, information regarding all medical records in possession of FSD, including records containing information about specific diagnoses or diseases, sexually transmitted diseases, and mental health. This also includes drug/alcohol abuse and treatment information (per 42 CFR 2.31). Unless the authorization is limited to signing and submitting an application on your behalf, you are consenting for your authorized representative to provide and receive protected health information (PHI).

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 and 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.

I/we understand:

- I/we am/are responsible for the information given by my/our authorized representative, including any information that may be incorrect.
- This authorization is voluntary and has no expiration date but can be cancelled in writing at any time through the same ways listed on page 2 for returning this form. I do not need to sign this form to receive FSD services.
- I/we can request a copy of information disclosed to my authorized representative.
- FSD has no control of the use of information after the information is given to the authorized representative.

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
Your signature
Date
Spouse (or second parent) signature
Date
Section 4: Authorized representative agreement and acceptance.
Representative's Name (If Representative is an organization, fill in its Contact Person's information here.)
First
Middle
Last
Suffix

Representative’s contact information
PO Box or Street Address
Apartment, Ste, or Trailer Number
City
State
Zip
Representative's email address
Representative's phone number
Organization or Facility contact information (if applicable)
Organization or facility name
PO Box or Street Address
Apartment, Ste, or Trailer Number
City

State
Zip
Organization or facility e-mail
Organization or facility telephone
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 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. I agree to be the applicant's authorized representative for the reason(s) stated on this form. Unless my authorization is limited to signing and submitting an application on behalf of the participant, I will report changes to FSD on behalf of the participant as needed.

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

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

If I am acting as an authorized representative due to my affiliation with an organization or facility:

- I do represent the organization or facility, and I have provided proof of my identity to 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.
- If a specific contact person is not named, within 10 days, the organization must provide the name, address and phone number of the organization’s contact person. If the contact person changes, the organization must contact FSD and provide the updated information within 10 days of the change.

If submitting electronically – I have agreed to submit this authorization 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
Authorized representative's signature
Date

Save **Print** **Reset**