**MONTGOMERY COUNTY DEPARTMENT OF JOB AND FAMILY SERVICES**

**Authorized Representative Designation**

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| --- | --- | --- |
| Applicant/Recipient's Name: | SSN: | DOB: |

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DIRECTIONS: This form is to be signed by the applicant/recipient listed above who is designating an Authorized Representative to act on his/her behalf.

# My signature below designates the person listed below as my Authorized Representative for the

# following programs:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| *□ Ohio Works First* | *□ Disability Financial Assistance* | *□ Food Assistance* | *□ Medicaid* | *□ PRC* |

|  |  |
| --- | --- |
| Name of designated Authorized Representative:  \ | Phone: |
| Address of Authorized Representative:  \ | |

*I* ***understand*** that my Authorized Representative must be 18 years of age or older and that as my Authorized Representative (s)he may be required to:

1. File an application on my behalf;
2. Represent me in an interview;
3. Receive instructions and/or correspondence on my behalf;
4. Explain my Rights and Responsibilities to me;
5. Provide information, documentation, and/or verification about my case as determined necessary by the Department of Job and Family Services; and/or
6. Represent me in a State or local Hearing.

*I* ***understand*** that it is my responsibility to notify the Department of Job and Family Services of any change in the named Authorized Representative.

*I* ***further understand*** that in situations where my Authorized Representative provides incorrect or fraudulent eligibility information, I may be held liable for any overpayments of assistance which occur as a result of that information.

|  |  |
| --- | --- |
| Signature of Applicant/Recipient: | Date: |
| Address: | Phone: |

|  |  |
| --- | --- |
| FOR AGENCY USE ONLY BELOW THE LINE | |
| **NOTE: When written authorization cannot be obtained because of the applicant/recipient=s incompetency or incapacity, the written statement may be waived. In this situation, the agency may assist in naming a responsible party to act as authorized representative for the assistance group.** | |
| Specify both the **nature** and the **means of verification** of the applicant/recipient=s inability to participate in the eligibility  determination process in the space below. | |
| NATURE: | HOW VERIFIED: |
|  |  |
| MCDJFS Employee’s Signature: | UNID: |

MCDJFS #156-C (Rev. 5/2013)