



BENEFITSPLUS

OF CLARK COUNTY

AUTHORIZED REPRESENTATIVE DESIGNATION

Applicant/Recipient's Name: _____ Case No.: _____ Date: _____

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

My signature below designates _____ as my Authorized Representative. I understand that my Authorized Representative may be 18 years of age or older and that as my Authorized Representative he/she may be required to:

1. file an application on my behalf, and/or
2. represent me in an interview, and/or
3. receive instructions and/or correspondence on my behalf, and/or
4. explain my Rights and Responsibilities to me, and/or
5. provide information, documentation, and/or verification about my case as determined necessary by the Department of Job & 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 & 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: _____ Telephone No.: _____

FOR AGENCY USE ONLY

Note: When written authorization cannot be obtained because of the applicant/recipient's incompetence 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:

Nature: _____

How verified: _____

Caseworker signature: _____ Unique I.D.: _____