MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION
APPOINTING AN AUTHORIZED REPRESENTATIVE

dss Missouri Department of Social Services

Section 1: Your information

Use this form if you would like to name someone, or an organization, to help you apply for MO HealthNet (MHN), Temporary Assistance (TA), Supplemental Nutrition Assistance Program (SNAP), and/or act on your behalf if you are eligible for MHN, TA, and/or SNAP. Family Support Division (FSD) calls this person an authorized representative.

If you have a guardian and/or conservator, they must be the one to appoint an authorized representative. If you have an attorney-in-fact appointed by a valid Power of Attorney under Missouri law, they may appoint an authorized representative on your behalf, or you may appoint your own.

If you have a spouse, both you and your spouse can name the same authorized representative by listing both names in Section 1 and both signing in Section 2. If you do not list both names and both sign, the authorized representative will ONLY be for the person whose name is listed and who signed.

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
- Section 2: Review the authorization information and sign your name(s).
- Section 3: Have the person you are appointing fill out and sign their name to verify 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 on page 3.

Your name

Date of Birth or DCN

Home address

Mailing Address

Phone number

Email address

I appoint as my/our authorized representative:

Name Compass Health Network

My authorized representative is one or more of the following (check all that apply):

☐ Spouse	☐ Legal Guardian	☐ Attorney	☐ Public Administrator
☐ Department of Mental Health	☐ Conservator	☐ Power of Attorney	■ None of these

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 annual reviews, report changes, and receive notices.
☐ Access my benefits and receive an EBT card.
☐ Access FSD account online communications.
☐ Access FSD account online communications only 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 only 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.
☐ Submit an application on my behalf, but have no other authority to act on my behalf or receive correspondence from FSD. This person is not allowed to receive protected health information.
■ Access FSD account online communications.
☐ Access FSD account online communications after my death.

Your name

Date of Birth or DCN

Section 2: Your authorization to be represented:

Based on your selections above, 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). 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 responsible for the information given by my/our authorized representative, including any information that may be incorrect.
- this authorization is voluntary and can be cancelled at any time. 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 authorization to be represented *

SIGN HERE

☑ I Accept
☐ I Decline

Section 3: Authorized representative agreement and acceptance

Individual acting as authorized representative: fill out and sign this section.

Representative's name	Date of birth or DCN (required for TA)
Representative's email address	Representative's phone number
Representative's mailing address	

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(s) stated on this form. 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.

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

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

Organization or facility name
Compass Health Network

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 theirbehalf. 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.

Unless my permissions are limited to submitting an application on behalf of the participant, I will report changes to FSD on behalf of the participant as needed. I will inform 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 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.

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

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