

**DESIGNATION OF  
AUTHORIZED REPRESENTATIVE**

CASE # \_\_\_\_\_

Pursuant to Section 1014.1 of the Ohio Public Assistance Manual, I \_\_\_\_\_

Person in Need

hereby authorize the named individual listed below to represent me in the following matters:

Check appropriate boxes where you want the authorized representative to assist you.

- My application for public assistance/food stamps and determination of eligibility including any State Hearings.
- To receive any public assistance/health care card or food stamp benefits for which I am duly eligible for. The authorized representative will ensure that I receive these benefits monthly.
- My reapplication/recertification of public assistance/food stamp benefits, including any State Hearings.

The authorized representative is:

\_\_\_\_\_  
Name of Individual

\_\_\_\_\_  
Street

\_\_\_\_\_  
City State Zip

This authorization to represent is valid only until the next reapplication or my case closes, whichever occurs first.

I understand that if the authorized representative provides incorrect or fraudulent eligibility information, that I, the assistance group may be held liable for any overpayments which occur. I, like the authorized representative, wish to receive all notices and correspondence regarding the status of my case.

\_\_\_\_\_  
Signature Date

\_\_\_\_\_  
Social Security Number

**NOTICE TO AUTHORIZED REPRESENTATIVE**

You have agreed to act on behalf of an assistance group in need of public assistance/health care and/or food stamp benefits. This agreement means that you will apply on behalf of the assistance group; receive benefits where appropriate for them and their care, and do a reapplication on behalf of the assistance group as required by the Lucas County Job & Family Services.

You, as the authorized representative are responsible for making an accurate and complete disclosure of all information necessary for determination of eligibility. If you provide incorrect or fraudulent eligibility information, the assistance group may still be held liable for any overpayments which occur. If it is determined that you, as the authorized representative, gave incorrect information intentionally through no fault of the assistance group, a referral will be made to the County Prosecutor to determine if fraud occurred on your part. If fraud is proven, you may be found liable for any overpayment. If, as the authorized representative, you are the legal guardian or legal trustee for the assistance group, you will be held responsible for the overpayments.

I, as the authorized representative, understand that I stand in the place of the assistance group in complying with the authorization given to me.

\_\_\_\_\_  
Authorized Representative Date

\_\_\_\_\_  
Street

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
Phone

ORIGINAL - TO CASE  
COPY - GIVE TO RECIPIENT