North Carolina Department of Health and Human Services
Division of Social Services
Designation of Authorized Representative

A. Applicant Consent:

Please complete this section if you are the applicant. Check all boxes that apply.

☐ I give permission for my Authorized Representative to apply for benefits on my behalf. This person knows my circumstances well enough to answer any questions for Food and Nutrition Services program purposes. I understand my household and the authorized representative are equally responsible for incorrect or incomplete information provided by my authorized representative.

☐ I want my Authorized Representative to get an EBT card and purchase food for me.

_____ _____ _____
(Print Name) (Signature) (Date)

B. Authorized Representative Information and Consent:

Please complete this section if you are the Authorized Representative. Check all boxes that apply.

☐ I have Power of Attorney for the applicant and will represent the person named above in applying for Food and Nutrition Services benefits and use an EBT card to purchase food for the household. I understand I am solely responsible for Food and Nutrition Services benefits traded for cash, firearms, ammunition, explosives, controlled substances, or anything other than eligible food with this EBT card.

☐ I have been asked by and agree to apply for benefits for the person named above.

☐ I have been asked by and agree to get an EBT Card, and purchase food for the person named above. I understand I am solely responsible for Food and Nutrition Services benefits traded for cash, firearms, ammunition, explosives, controlled substances, or anything other than eligible food with this EBT card.

☐ I am the Authorized Representative of an Alcohol/Drug Treatment Center. (Not applicable for SNAP)

I understand I am responsible along with the household for any incorrect or incomplete information I provide. I also understand I must provide the information below in order to be considered for an Authorized Representative.

My full name is: _____ Date of Birth: _____

Social Security Number: _____ Race: _____ Sex: _____ Ethnicity: _____

Address: _____

_____ Phone #: _____

Name of Alcohol/Drug Treatment Center (Not applicable for SNAP): _____

_____

By signing this form, I certify that the information provided is true and complete.

_____ _____
(Authorized Representative Signature) (Date)

For Office Use Only

Applicant Name: _____ FSIS ID #: _____Worker #: _____

Authorized Representative: Approved ☐ Disapproved ☐ Disqualified from: _____to: _____

Agency Disqualification Override Date: _____ Reason: _____

Override Authorized by: _____

Date EBT Updated: _____ Effective Certification Period: _____