Janet T. Mills
Governor

Jeanne M. Lambrew, Ph.D.
Commissioner

Maine Department of Health and Human Services
Office for Family Independence
19 Union Street
11 State House Station
Augusta, Maine 04333-0011
Tel.: (207) 624-4168; Toll-Free: (800) 442-6003
TTY: Dial 711 (Maine Relay); Fax: (207) 287-3455

Appointment of an Authorized Representative

You have the right to appoint an authorized representative to act on your behalf with the Department. If you want to name a person or organization as your authorized representative, use this form.

We are committed to the privacy of your health information. Please read this form carefully.

Individual's Name: _____

Individual's Date of Birth: _____

Individual's Social Security Number: _____

Individual's Address: _____

I (individual named above) hereby appoint the following individual/organization to act as Authorized Representative for me.

Authorized Representative's Name: _____

Address: _____

Telephone number: _____

Email address: _____

Existing legal authority (if any) for individual/organization to act on my behalf (check all that apply and attach copy of documentation):

☐ *Guardianship*

☐ *Power of Attorney*

☐ *Advance Healthcare Directive*

☐ *Other:* _____

By making this appointment, I want my Authorized Representative to (check all that apply):

☐ Sign and submit an application on my behalf (including an electronic application)

☐ Sign and submit a recertification form on my behalf (including an electronic recertification)

☐ Receive copies of Notices of Decision and all other written communications from the Department; I'm aware I may also need to complete an Authorization to Release Information form

☐ Obtain SNAP benefits on behalf of my household

☐ Represent me at a fair hearing; I'm aware that I may also need to complete an Authorization to Release Information form

☐ Other (please describe) _____

☐ Act on my behalf in all other matters with the Department of Health and Human Services; I'm aware I may also need to complete an Authorization to Release Information form

- My authorized representative's authority is limited to the task or tasks I have delegated, above.
- This appointment is valid until:
  - I change this appointment in writing by notifying the Department that this Authorized Representative is no longer authorized to act on my behalf; or
  - My Authorized Representative informs the Department in writing that he/she is no longer acting as my Authorized Representative.
- I understand that taking back this appointment does not apply to any documents signed by or sent to my Authorized Representative before I took back the appointment.
- I understand that if I want my Authorized Representative to receive copies of the Notices of Decision and all other written communications from the Department, the information shared will be for all programs in which I participate that are administered by the Department.
- I understand that an appointment of a representative for the TANF or SNAP programs is a representative for both me and my household and that my household will be liable for any over issuance of SNAP or TANF benefits that results from erroneous information given by the authorized representative.

I am signing this form voluntarily, and I have the right to a signed copy of this form if I request one.

Signature of the Individual: _____ Date: _____

For the Authorized Representative

I (Individual or Organization Named as Authorized Representative) hereby agree to:

- Fulfill all above-designated responsibilities on behalf of the individual who appointed me as his/her Authorized Representative;
- Maintain the confidentiality of any information regarding the individual who appointed me as his/her Authorized Representative;
- Adhere to the regulations 42 C.F.R. § 431(F) and at 45 CFR § 155.260(f) (relating to confidentiality of information), 42 C.F.R. § 447.10 (relating to the prohibition against reassignment of provider claims as appropriate for a facility or an organization acting on the facility's behalf), as well as all other applicable state and federal laws concerning conflicts of interest and confidentiality of information.
- I acknowledge that I cannot act as an authorized representative if I have been disqualified from SNAP for an intentional program violation unless there is no one else suitable to represent the individual.

Signature of the Authorized Representative: _____ Date: _____