

**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 Assistance 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 Assistance and use an EBT card to purchase food for the household. I understand I am solely responsible for food assistance 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 assistance 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.

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: \_\_\_\_\_

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: \_\_\_\_\_