## COUNTY OF LOS ANGELES

**DEPARTMENT OF PUBLIC SOCIAL SERVICES**

**AUTHORIZED REPRESENTATIVE DESIGNATION FOR CALFRESH/CASH BENEFITS**

### Date:

**Case Name:**

**Case Number:**

**Worker Name: Worker ID: Worker Phone Number:**

**Customer ID:**

COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC SOCIAL SERVICES

**AUTHORIZED REPRESENTATIVE DESIGNATION FOR CALFRESH/CASH BENEFITS**

|  |  |  |
| --- | --- | --- |
| CASE NAME | CASE NUMBER | DIST. NO. |

### Providers of prepared meals for the homeless are not permitted to serve as Authorized Representatives (AR) for CalFresh/Cash Aid benefits for residents of temporary shelters for the homeless.

A responsible household member or (if the household consists of minors) the Eligibility Worker may designate an AR as follows:

1. To make an application and/or pick up and use CalFresh/Cash Aid benefits when: in an independent living arrangement; or a resident of a Board and Care/Room and Board facility - complete Section **A**.

**~~TES~~T**

1. To make an application and/or pick up CalFresh benefits when a resident of a Drug or Alcohol Treatment Center - complete Section **B-2**, the AR mush complete Section **B-1**.

### SECTION A

I authorize the person identified below to act as my/the household's AR to: (check the boxes that apply) Make an application for my/the household to participate in the CalFresh Program.

 Pick up and use my/the household's CalFRESH/Cash benefits (i.e. CalWORKs, Refugee Cash Assistance, General Relief, & Cash Assistance Program for immigrants) on my/its behalf.

**USE**

 Pick up and use my CalFresh benefits and pick up and use my General Relief (GR) or Refugee Cash Assistance (RCA) benefits on my behalf. Person Authorized:

Name Relationship

(IF FACILITY, ENTER FACILITY NAME)

(AUNT, MOTHER, FRIEND, ETC.)

Address Phone #: Area Code ( )

# ~~ONL~~Y

I understand that my/the CalFresh/Cash benefits household is liable for any CalFresh overissuance or Cash overpayment which results from erroneous information given by AR.

The AR is needed to act on my/the household's behalf because:

|  |  |  |  |
| --- | --- | --- | --- |
| DATE | SIGNATURE OF PAYEE/RESPONSIBLE HOUSEHOLD MEMBER OR ELIGIBILITY WORKER (IF HOUSEHOLD CONSISTS ONLY OF MINORS) | | |
|  |  | | |
| DATE | ELIGIBILITY SUPERVISOR'S SIGNATURE | DATE | DISTRICT DIRECTOR'S SIGNATURE |
|  |  |  |  |

### SECTION B.

1) We

(ENTER NAMES OF FACILITY EMPLOYEES WHO WILL BE AR)

have been given the authority to act as ARs for the residents of:

(NAME OF FACILITY)

We understand that the facility is responsible to the Department of Public Social Services for accurately reporting all information related to the below signed resident's situation. We have reviewed the "Special CalFRESH Requirements for Drug/Alcohol Treatment Centers" and understand our facility's responsibilities. We also understand that the facility will be held liable for any overissuances resulting from information reported by us.

**DO NOT**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| DATE | SIGNATURES OF AR | CA DRIVER'S LICENSE or CA ID  (OPTIONAL) | SOCIAL SECURITY NUMBER  (OPTIONAL) | TITLE |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

2)

I authorize any of the employees of the

DATE

**D**

**IS**

**TRIBUTE**

listed above to

(NAME OF FACILITY)

act as my AR in making an application for the CalFRESH Program and in picking up and using my CalFresh benefits because I am a participating

resident of a drug/alcohol treatment center.

SIGNATURE OF RESIDENT

PA 1857 (03/03)

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