



MISSOURI DEPARTMENT OF SOCIAL SERVICES  
DIVISION OF FAMILY SERVICES  
**IM AUTHORIZED REPRESENTATIVE**

**You may contact the Division of Family Services to apply in your own behalf. You do not need to sign this form in order to apply for assistance.**

**I HEREBY AUTHORIZE**

NAME

TELEPHONE NUMBER

ADDRESS

to make application for \_\_\_\_\_ with the Division of Family Services, in my behalf. This authorization expires if application to DFS has not been made and is not made within thirty (30) days from the date this authorization is signed.

I understand that I am responsible to repay any benefits to which I am not entitled whether or not the payment of benefits results from the action or non-action, intentional or otherwise, on the part of my representative named above or myself.

If this authorization is used to make an application for assistance on my behalf, I agree that the individual named above as my personal representative, is allowed access to any information in my casefile, including medical records. This authorization shall continue until final disposition of the application or until specifically revoked by me, whichever is earlier.

SIGNATURE

DATE