IDAHO DEPARTMENT OF HEALTH & WELFARE

Authorized Representative Form

HW2019 | Rev 08/2018

You can name someone as an authorized representative.

You may give a trusted person, such as a friend, partner, or third party caseworker permission to talk about this application with us, see your information, and act for you on all matters related to this application, including getting information about your application and signing your application on your behalf. This person is called an "authorized representative."

If you ever need to change your authorized representative, contact the Department to complete a new Authorized Representative Form.

If you're a legally appointed representative for someone on this application, submit proof with the application.

Your Information

First Name	Middle Name	Last Name	Date of Birth

Social Security Number	Case Number (if known)	Daytime Phone	

Address	City	State	Zip Code	County

Tell us who you want to name as your authorized representative

First Name	Middle Name	Last Name	Relationship to applicant

Organization Name (if third party caseworker or Agent/Broker)	Organization ID (if applicable)

City	State	Zip Code	County

Phone	Phone type (choose one)	Email
	☐ Home ☐ Work ☐ Cell	

Address	Apartment or suite number

By signing, you allow this person to sign your application, get official information about this application, and act for you on all future matters with the Department of Health and Welfare.

Printed Name of Applicant	Signature of Applicant	Date

Return completed form by Fax to: 1(866)434-8278