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COLUMBIANA COUNTY DEPARTMENT OF JOB & FAMILY SERVICES
AUTHORIZED REPRESENTATIVE FORM

Name of Authorized Representative: _____

Relationship:_____ Telephone: _____

Address: _____

_____

I authorize _____ to act on my behalf and to represent me in the following duties: (Please check all that apply)

____ To make application on my behalf.
____ To act as my contact person.
____ To act on my behalf for state hearing or county conference.
____ To pick up/ receive my food stamps.
____ All of the above.
____ Other: _____

This designation is effective: ___ From _____ To _____
___ Until my next reapplication.

_____ _____
Signature of Client Date Signature of Witness Date

I, _____ accept the designation of Authorized Representative

for_____. I understand that I am responsible for providing accurate and correct information to the agency. I also understand that I could be held liable for intentionally providing incorrect information.

_____
Signature of Authorized Representative Date

_____
Signature of Witness Date

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