



AUTHORIZED REPRESENTATIVE FORM

Use this form to give a trusted person permission to talk about your application with us, see your information, and act for you on matters related to your application, including getting information about your application and signing your application on your behalf. They may also complete your 3SquaresVT or Reach Up interview on your behalf, if necessary. This person is called an **Authorized Representative**. If you are a legally appointed representative for the applicant (i.e., power of attorney or legal guardian), please submit proof with this form.

Applicant name _____

Social Security number _____ **Date of birth** _____

Name of Authorized Representative (first, middle, last & suffix (Jr., Sr., III, etc.))		Phone number () -
Address		Apartment or suite number
City	State	ZIP code
Organization name (if applicable)		ID number (if applicable)

Check one:

- The person named above is a new Authorized Representative.
- The person named above will replace any existing Authorized Representative(s) I have previously named.
- I wish to revoke Authorized Representative permissions from the person named above.

To change your Authorized Representative at any time, you must submit another Authorized Representative Form (139REP). To request another form call the Benefits Service Center at 1-800-479-6151.

CAREFULLY READ THROUGH THE TERMS ON THE BACK BEFORE SIGNING.

By signing, you agree to the terms on the back, and you allow the Authorized Representative named here to sign your application, get official information about your application, and act for you on all future matters with this agency. If you checked the last box above and are *revoking* permissions, your signature here will instead *prohibit* the person listed above from acting on your behalf.

Your signature	Date (mm/dd/yyyy)
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IMPORTANT NOTE: This form should **ONLY** be used to assign, change, or remove an Authorized Representative that acts for you in matters regarding Economic Services Programs such as VPharm, Medicaid for the Aged, Blind and Disabled (MABD), 3SquaresVT, Reach Up, Fuel, General Assistance, PSE, and Essential Person. **DO NOT** submit this form to Vermont Health Connect (VHC). To designate an Authorized Representative for matters regarding your VHC health care coverage, you need to submit an "Appendix A" form, instead. You can request an Appendix A form by calling **1-855-899-9600**.

Confidentiality and Information-Sharing

Information about my application and benefits is confidential and protected by state and federal law. I understand that the Economic Services Division (ESD) will not share any information about me unless:

- It is for purposes directly connected with program administration;
- It is allowed by law or a court order; or
- I give my permission.

If I have named someone as an Assistor or **Authorized Representative**, I give ESD and that person permission to communicate with each other and share information about my household and myself. This may include, but is not limited to, the following kinds of information:

- Information or proofs needed to complete my application.
- The status of my application including the program(s) I am enrolled in and the effective date(s) of enrollment.
- The reason I am not eligible for a benefit, if my application is denied or my benefits end.
- The effective date(s) of my renewal(s) for benefits and any outstanding information or verifications needed to complete my renewal.

I understand that this information will be used to help with my application and continued eligibility for the programs I have applied for. I know:

- I do not have to give permission to release this information.
- If I do not give permission it will not affect my eligibility for, or enrollment in, benefits.
- ESD is not responsible for what is done with my information after it shares it.
- I may change or stop this permission at any time by notifying ESD. **To stop permission immediately, I may call the Benefits Service Center at 1-800-479-6151.** To change or remove my Authorized Representative, I can request an Authorized Representative form (139REP) from the Benefits Service Center. I may also send my changes or request to stop permission in writing to DCF – Economic Services Division, Application and Document Processing Center, 280 State Drive, Waterbury, VT 05671-1500. Making changes or stopping permission will not affect previously shared information.
- If I do not stop this permission, it will be in effect as long as I am receiving benefits from ESD.
- If I have any questions about this permission, I may get answers by calling the Benefits Service Center at **1-800-479-6151**.
- I am entitled to a copy of this form and may get one by calling the Benefits Service Center at **1-800-479-6151**.

Please return this form to:

DCF – Economic Services Division
Application and Document Processing Center
280 State Drive
Waterbury, VT 05671-1500

For more information, call the Benefits Service Center at 1-800-479-6151 (711 if hearing impaired).