STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF WELFARE AND SUPPORTIVE SERVICES

JOE LOMBARDO
Governor

RICHARD WHITLEY, MS
Director

ROBERT THOMPSON
Administrator

DESIGNATION OF AUTHORIZED REPRESENTATIVE

Case Name: ______________________________ Case ID: ______________________________

Applicants and beneficiaries can designate an individual or organization to act responsibly on their behalf. This includes assisting with the individual's application for assistance, renewals of eligibility and other ongoing communications with the agency. This designation must include the applicant's signature, either electronically, telephonically or handwritten.

A designated authorized representative agrees to act responsibly on behalf of the applicant/recipient by providing all necessary information to determine eligibility for assistance. The rights and obligations of an authorized representative are the same as if they were the applicant/recipient to the extent of the applicant/recipient's financial ability to pay.

I. DESIGNATION OF AUTHORIZED REPRESENTATIVE BY APPLICANT/RECIPIENT

I, ____, request the following person/agency:
Print Name of Applicant/Recipient

____ to be my authorized representative.
Print Name of Person or Agency

I understand that I or the designated authorized representative may terminate this designation in writing at any time.

Signature of Applicant | Date of Birth | Date

Relationship to Applicant if Signature Is Not Applicant (Must be a Family Member) | Date

STATEMENT OF DESIGNATED REPRESENTATIVE

I believe the above-named applicant/recipient understands the nature and consequences of his/her acts and is able to exercise his/her own will. I certify the above-named applicant/recipient made the decision to designate me as his/her representative under no threat or duress of any kind.

I certify under penalty of perjury, the information I provide is correct and complete to the best of my knowledge.

Signature of Representative | Position/Relationship | Print Name | Date

Address | Telephone Number

Hospital, Nursing Home or County Agency

II. DESIGNATION OF AUTHORIZED REPRESENTATIVE BY OTHER

I, ____, have made a good faith effort to contact family members and/or any legal guardian of the applicant/recipient. My efforts to find a family member to act as authorized representative/provide information or a legal guardian have been unsuccessful. I therefore request to be designated as an authorized representative for the above mentioned applicant/beneficiary.

I certify under penalty of perjury, the information I provide is correct and complete to the best of my knowledge.

Signature of Representative | Relationship | Print Name | Date

Address | Telephone Number

Hospital, Nursing Home or County Agency