

**STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF WELFARE AND SUPPORTIVE SERVICES
ENERGY ASSISTANCE PROGRAM**

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Las Vegas, NV 89121-4397
(702) 486-1404 · Fax (702) 486-1441

Case Name: _____

Case UPI: _____

DESIGNATION OF AUTHORIZED REPRESENTATIVE

I. DESIGNATION OF AUTHORIZED REPRESENTATIVE BY APPLICANT/CLIENT

I, _____, request _____
Print Name of Applicant/Client Print Name of Person/Agency
act as my **primary** authorized representative which allows this individual to obtain information regarding my case. As a primary authorized representative, this individual will receive copies of all requests for information and notices and will hold the same responsibility as myself in securing information for determining eligibility and reporting responsibilities. In addition, they are authorized to sign any and all documents on my behalf.

I, _____, request _____
Print Name of Applicant/Client Print Name of Person/Agency
act as my **secondary** authorized representative which allows this individual to obtain information regarding my case. As a secondary authorized representative, this individual may provide information and will receive copies of all requests for information and notices.

I understand the time period of this designation begins _____ and will cease at the end of the current certification period, however, I may terminate this authorization in writing at any time prior to the end of the certification period.

Signature of Applicant/Client

Date

II. STATEMENT OF DESIGNATED REPRESENTATIVE

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

As the **primary** authorized representative, I agree to act responsibly on behalf of the above-named applicant/client in the above-mentioned capacity. I understand my rights and obligations, as an authorized representative, are the same as if I were the applicant/client and I understand I may be liable for any overpayment resulting from inaccurate information I may provide.

As the **secondary** authorized representative, I agree to act responsibly on behalf of the above-named applicant/client in the above-mentioned capacity. I understand I will receive copies of all requests for information and notices and may provide any information to assist in the eligibility process. I understand I have no authority to sign on behalf of the above-named applicant/recipient.

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