



### Assistance with Completing this Application

- You can choose an authorized representative for
- Medical Assistance
  - Cash Assistance
  - Child Care
  - Food Benefits
  - EBT Card

You can give a trusted person permission to talk about this application with us, see your information, and act for you on 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 Delaware Health and Social Services (DHSS). If you're a legally appointed representative for someone on this application, submit proof with the application.

1. Name of authorized representative (First Name, Middle Name, Last Name, & Suffix)		
2. Address		3. Apartment or Suite Number
4. City	5. State	6. Zip Code
7. Phone Number ( ) -		

**Authorized Representative For My EBT Card**

I, \_\_\_\_\_ want  
 \_\_\_\_\_  
**Your Name** **Your Representative's Name**

to be my representative to be issued an Electronic Benefit Transfer (EBT) card for my food benefit account and will be able to use it to purchase food. I understand that this gives the representative access to my food benefits and that any benefits spent by the representative will not be replaced.

8. Organization name	9. ID number (if applicable)
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 this agency.	
10. Your signature	11. Date (mm/dd/yyyy)

**For certified application counselors, navigators, agents, and brokers only.**

Complete this section if you're a certified application counselor, navigator, agent, or broker filling out this application for somebody else.

1. Application start date (mm/dd/yyyy)	
2. First Name, Middle Name, Last Name, & Suffix	
3. Organization name	4. ID number (if applicable)