



Program:	Branch:	Case number:
Case name:		Worker ID:

## Authorized Representative and Alternate Payee

You may choose someone to be an authorized representative, alternate payee or both. Please use this form to tell us about the person you have chosen. You must sign this form. The authorized representative and/or the alternate payee must also sign this form. This form will be used to inform you if an alternate payee is chosen for you by the Oregon Department of Human Services (ODHS).

Client's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Client's Social Security number, case number or OHP ID number: \_\_\_\_\_

### Assigning an authorized representative

#### Rights and liability of an authorized representative

An authorized representative may do things such as the following for the client(s): Sign and submit applications and renewals, report changes, and receive copies of notices and other communication.

**An authorized representative acts on behalf of the client(s) for the ODHS and Oregon Health Authority (OHA) programs they apply for or receive (except the Temporary Assistance for Domestic Violence Survivors program and in some cases long-term care services). This will apply to all clients on the case.** The authorized representative listed on this form will replace any previously designated authorized representatives on the case.

The person or organization that is chosen as the authorized representative will remain the authorized representative until:

- A client on the case tells ODHS or OHA that they want to end this approval; or
- The authorized representative tells ODHS or OHA that they want to end this approval; or
- The person or organization is no longer permitted to act as the client's authorized representative

*If the authorized representative gives wrong or incomplete information to ODHS or OHA and the information results in an overpayment, the clients and any other liable parties will have to pay back what they should not have received. If the authorized representative knowingly withholds or gives wrong information, the authorized representative will also have to pay it back.*

*The authorized representative must maintain the confidentiality of any information provided by ODHS or OHA regarding anyone listed on the application or case as well as adhere to any other relevant state and federal laws concerning conflicts of interest and confidentiality of information.*

Oregon Administrative Rules: 461-115-0090, 410-200-0111, 414-175-0006

## Authorized representative information

Name (last, first):

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Organization (if applicable):

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Age 18 or older?      Yes      No      Email address: \_\_\_\_\_

Mailing address: \_\_\_\_\_

Preferred spoken language: \_\_\_\_\_ Phone number: \_\_\_\_\_

Phone type (please indicate):      Home      Cell

Authorized representative may be contacted by (please indicate):      Text      Voicemail

Please mark all that apply to the authorized representative (required):

- You are a homeless meal provider (public or private non-profit)
- You are the owner of a restaurant which contracts to provide meals at low or reduced prices
- You are involved in processes to approve or issue ODHS/OHA benefits
- You are the owner of a business which accepts Electronic Benefit Transfer (EBT) cards for payment
- You are currently serving an Intentional Program Violation for an ODHS/OHA program
- None of the above

## Authorized representative agreement

Client signature: \_\_\_\_\_ Date: \_\_\_\_\_

Authorized representative signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Assigning an alternate payee

## Rights and liability of an alternate payee

An alternate payee may use program benefits on the client(s) behalf. If the alternate payee misuses the program benefits, the client cannot get them back.

The person or organization chosen as the alternate payee will remain the alternate payee until:

- A client on the case or their authorized representative tells ODHS or OHA that they want to end this approval; or
- The alternate payee tells ODHS or OHA that they want to end this approval; or
- The person or organization is no longer permitted to act as the client(s) alternate payee

Oregon Administrative Rules: 461-165-0035

## This person or organization is my alternate payee for (check all that apply):

Supplemental Nutrition Assistance Program (SNAP)

Temporary Assistance for Needy Families (TANF) or Refugee Assistance Programs (REF)

General Assistance — Utility and Personal Incidental Funds (GA)

Oregon Supplemental Income Program (OSIP)

## Alternate payee information

Name (last, first):																						
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Organization (if applicable):																						
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Age 18 or older?      Yes          No      Email address: \_\_\_\_\_

Mailing address: \_\_\_\_\_

Preferred spoken language: \_\_\_\_\_ Phone number: \_\_\_\_\_

Phone type (please indicate):          Home          Cell

Authorized representative may be contacted by (please indicate):          Text          Voicemail

Please mark all that apply to the authorized representative (required):

- You are a homeless meal provider (public or private non-profit)
- You are the owner of a restaurant which contracts to provide meals at low or reduced prices
- You are involved in processes to approve or issue ODHS/OHA benefits
- You are the owner of a business which accepts Electronic Benefit Transfer (EBT) cards for payment
- You are currently serving an Intentional Program Violation for an ODHS/OHA program
- None of the above

## Alternate payee agreement

Alternate payee is designated by ODHS/AAA.

Client signature: \_\_\_\_\_ Date: \_\_\_\_\_

Alternate payee signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Submitting this form

You can use the ways below to return your completed form:

- **Return it to a local office:** Mail or drop off the form to a local office. You can look up your local office at <https://one.oregon.gov/general/LocateAnOffice>
- **Upload online:** Login or create an online account at <https://one.oregon.gov>
- **Email:** You can email documents to [oregon.benefits@odhsoha.oregon.gov](mailto:oregon.benefits@odhsoha.oregon.gov)
- **Fax:** You can fax documents to 503-378-5628
- **Mail:** You can mail documents to ONE Customer Service Center, PO Box 14015, Salem, OR 97309

## Our non-discrimination policy

The Oregon Department of Human Services (ODHS) and the Oregon Health Authority (OHA) do not discriminate against anyone. This means that ODHS|OHA will help all who qualify and will not treat anyone differently because of age, race, color, national origin, gender, religion, political beliefs, disability or sexual orientation.

You may file a complaint if you believe ODHS or OHA treated you differently for any of these reasons. To file a complaint with the state, you can call the Governor's Advocacy Office at 1-800-442-5238 (TTY 711) or write to their office at:

- **Mail:** Governor's Advocacy Office, 500 Summer Street NE, E17, Salem, OR 97301
- **Fax:** 503-378-6532
- **Email:** [odhs.info@odhsoha.oregon.gov](mailto:odhs.info@odhsoha.oregon.gov)

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact ONE Customer Service Center at [oregon.benefits@odhsoha.oregon.gov](mailto:oregon.benefits@odhsoha.oregon.gov) or 1-800-699-9075 (voice/text). We accept all relay calls.

**“Equal opportunity is the law!”**