

Date: _____
Case Name: _____
Case Number: _____
Worker Name: _____
Worker ID: _____
Worker Phone Number: _____
Customer ID: _____

INSTRUCTIONS:

A Designated Alternate Cardholder/Authorized Representative (AC/AR) is a responsible person that you trust. An AC/AR will have an EBT card in their name and Personal Identification Number (PIN) issued and **will have access to all your cash and/or your CalFresh benefits.**

- The designated Alternate Cardholder/Authorized Representative (AC/AR) is NOT REQUIRED to provide their birth date or Social Security Number (SSN). This information is only needed if the AC/AR wants to use the Customer Service Center telephone system to change their Personal Identification Number (PIN) or to get a replacement EBT card. If the AC/AR does not want to give the County this information they can change their PIN or get a replacement card by going to the County Office.
- Mark the box that shows you want the named AC/AR to have access to your CalFresh and/or cash benefits.
- Complete and sign this form.
- Have your AC/AR sign this form.
- Send or bring in the form to your Eligibility Worker in the County office.

New

Change

Remove

NAME OF DESIGNATED ALTERNATE CARDHOLDER/ AUTHORIZED REPRESENTATIVE: (PLEASE PRINT)	SOCIAL SECURITY NUMBER (optional)	BIRTHDATE: (optional)
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CERTIFICATION:

I want the person named as my Designated Alternate Cardholder/Authorized Representative to have access to:

Cash Aid only

CalFresh only

Cash aid and CalFresh

I understand that Los Angeles County will issue an EBT card to the Designated Alternate Cardholder/Authorized Representative at my request. I further understand the AC/AR will have access to **ALL** my cash and/or CalFresh benefits. Los Angeles County is not responsible for lost or stolen benefits. I understand that if my EBT card is used by me, my AC/AR or any other person to whom I or my AC/AR voluntarily give the EBT card and PIN, the transaction is considered authorized and the **benefits will not be replaced.** I can change who can access my cash aid and/or CalFresh benefits by calling my Eligibility Worker.

SIGNATURE OF PARTICIPANT: (USE YOUR LEGAL SIGNATURE)	PHONE NUMBER:	DATE:
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To be signed by Designated Alternate Card Holder/Authorized Representative (AC/AR).

I agree to be a Designated Alternate Card Holder/Authorized Representative. By using this card, I agree to the terms of the cash aid/CalFresh Electronic Benefit Transfer (EBT) program.

SIGNATURE OF DESIGNATED ALTERNATE CARD HOLDER/ AUTHORIZED REPRESENTATIVE SIGNATURE: (USE YOUR LEGAL SIGNATURE)	PHONE NUMBER:	DATE:
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Report lost or stolen card IMMEDIATELY by calling toll free _____.

REMINDER

It is **YOUR** responsibility to call the toll-free customer service telephone number _____ to stop another household member's, or Designated Alternate Cardholder's, or Authorized Representative's access to your EBT account.