



Jefferson Parish Community Action Programs
DESIGNATED AUTHORIZED REPRESENTATIVE FORM

Community Center Name: _____

Community Center Address: _____

Date: _____

I, (Full Name) _____, (SSN) _____

do hereby authorized (Full Name) _____ as my designate representative to apply for LIHEAP services on my behalf because:

____ I am homebound and unable to travel to community center.

____ I am, (circle one) **sick or injured** and unable to travel community center.

____ Other (please use the space below to write any conditions that are not covered above)

I understand that if I knowingly give **incomplete, inaccurate, or incorrect** information I am subject to criminal prosecution under Title 18 of the U.S. Code.

Signature: _____

Customer Signature

Agency Representative

(Include a current copy of authorized designate representative state ID or state driver license)