STATE OF MISSOURI
DEPARTMENT OF HEALTH AND SENIOR SERVICES
WIC AND NUTRITION SERVICES

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ALTERNATIVE REPRESENTATIVE OR PROXY REQUEST FORM

NAME OF PARTICIPANT	STATE ID NUMBER	HOUSEHOLD ID NUMBER

NAME OF AUTHORIZED REPRESENTATIVE

I, _____, as the Authorized Representative assign Alternative Representative or Proxy designation to the following person(s):

NAME OF ALTERNATIVE REPRESENTATIVE OR PROXY	TYPE (CHECK ONE)	RELATIONSHIP	PHONE NUMBER
	☐ Alt Rep ☐ Proxy		
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- I agree that any alternative representative and proxy will correctly use my WIC benefits to buy WIC-approved food at an authorized WIC retailer.
- I agree that any program violation by an alternative representative or proxy may result in my ineligibility or removal from the program. The alternative representative, proxy, or I may be subject to civil or criminal prosecution.
- I will inform the alternative representatives or proxy that the local agency will require a form of identification (ID) prior to issuing benefits and of their responsibility for the security of the eWIC card for the members of this household.

I certify that the information I have provided is correct to the best of my knowledge. I understand that providing false information or participating in fraudulent activity with regard to my eWIC card may result in paying the state agency in cash the value of food benefits improperly issued.

SIGNATURE OF AUTHORIZED REPRESENTATIVE	DATE