Commonwealth of the Northern Mariana Islands
Department of Community and Cultural Affairs
LOW INCOME HOME ENERGY ASSISTANCE PROGRAM
Caller Box 10007, Saipan, MP 96950

AUTHORIZED REPRESENTATIVE FORM

SECTION 1 Authorized Representative Designation ***(if applicant is able to sign)***

Part A – ***to be filled out by Applicant***

LIHEAP Applicant Name	Date of Birth (mm/dd/yy)
Email Address	LIHEAP Case Number:
I certify that I have chosen the following person or organization to be the authorized representative for myself and any dependent children under the age of 18 for whom I am the custodial parent and that I understand the duties and responsibilities this person or organization will have.	
Signature	Date

Part B – to be filled out by Authorized Representative.

B1. COMPLETE IF AUTHORIZED REPRESENTATIVE IS A PERSON

I certify that I will at all times maintain the confidentiality of any information regarding the applicant or member set forth above and, if applicable, the dependent children of such applicant or member, that is provided to me by DCCA-Low Income Home Energy Assistance Program (LIHEAP).
If I am also a provider, staff member, or volunteer affiliated with an organization, and am acting in my capacity as a provider, staff member, or volunteer in connection with my designation as an authorized representative, I certify that I will at all times adhere to all applicable CNMI and Federal laws and regulations regarding confidentiality of information and conflicts of interest.

Authorized representative's name *(first, middle, last)*	Authorized representative's last SS# (last four digits)
Authorized representative's mailing address	Authorized representative's email address
Authorized representative's signature	Date (mm/dd/yyyy)

B2. COMPLETE IF AUTHORIZED REPRESENTATIVE IS AN ORGANIZATION

I certify, on behalf of the organization set forth below, that such organization will at all times maintain the confidentiality of any information regarding the applicant or member set forth above and, if applicable, the dependent children of such applicant or member, that is provided to the organization by DCCA-LIHEAP.

I, the provider, staff member, or volunteer of the organization set forth below, completing this form, certify on behalf of myself and on behalf of the organization I represent, that any providers, staff members, or volunteers acting on behalf of the organization in connection with this authorized representative designation will at all times adhere to all applicable CNMI and Federal laws and regulations regarding confidentiality of information, and conflicts of interest.

Signature of provider, staff member, volunteer completing form	Date (mm/dd/yyyy)
Authorized representative **Organization name**	Email address