APPOINTMENT OF AUTHORIZED REPRESENTATIVE FOR SUPPLEMENTAL SECURITY INCOME (SSI)

Instructions: Complete and return this form to DHS / State SSI Program, P.O. Box 6680, Madison, WI 53716-0680. Retain a copy for your records. Personally identifiable information collected on this form is confidential and will be used for identification purposes only.

SSI Recipient Information:

Name: _____
(First, Middle, Last)

Social Security Number: ___ ___ ___ – ___ ___ – ___ ___ ___ ___

Address: _____
(Street, City, State, Zip Code)

Telephone Number: (___ ___ ___) ___ ___ ___ – ___ ___ ___ ___
Area Code

I appoint _____ to act as my **primary**
(Print full name)
personal representative in regard to my eligibility and benefits from the State SSI Program administered by the Wisconsin Department of Health Services. This person may provide information to the Program and may obtain information about my entitlement on my behalf.

I appoint _____ to act as my **secondary**
(Print full name)
personal representative in regard to my eligibility and benefits from the State SSI Program administered by the Wisconsin Department of Health Services. This person may provide information to the Program and may obtain information about my entitlement on my behalf when my primary personal representative is unable to do so.

The period of the appointment of the above personal representative(s) will continue until revoked in writing by myself.

SIGNATURE - Recipient _____ Date Signed _____