

**ADD OR REMOVE AN AUTHORIZED BUYER OR ALTERNATE PAYEE
FOR FOODSHARE BENEFITS**

Instructions: Use this form to add or remove an **authorized buyer** or **alternate payee** for your FoodShare benefits.

- An **authorized buyer** is a person who can use your FoodShare benefits to buy food for your household. If you add an authorized buyer, you *and* that person will each get an individual QUEST card connected to your benefits.
- An **alternate payee** is a person who uses FoodShare benefits on your behalf. If you add an alternate payee, only that person will get a QUEST card with their name on it. You will not get a card.

You can remove an authorized buyer or alternate payee at any time by contacting your agency or filling out this form. Submit the completed form to your agency.

To find your agency, go to dhs.wisconsin.gov/forwardhealth/imagency/index.htm or call Member Services at 1-800-362-3002.

Any personally identifiable information entered below will be used only by FoodShare Wisconsin for the direct management of benefits.

Primary Card Holder Name	Case Number
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By checking the box(es) below, I certify that:

- I want _____ added as an authorized buyer who can use my FoodShare benefits to buy food for my household. I understand that we will both be given QUEST cards and that my authorized buyer's QUEST card will be mailed to my address as the person getting FoodShare benefits.

Note: If the address you provide below is not the address on file, your address will be updated in our system.

Street Address

City	State	Zip Code
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- I want _____ removed as an authorized buyer from my FoodShare benefits.

- I want _____ added as an alternate payee who will use my FoodShare benefits to buy food for my household. I understand that my alternate payee will be given a QUEST card instead of me. My alternate payee's QUEST card should be mailed to:

Street Address

City	State	Zip Code
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- I want _____ removed as an alternate payee from my FoodShare benefits.

If you are adding an authorized buyer or alternate payee, check the boxes below to show you understand that:

- Any transaction on my FoodShare account is considered authorized, and benefits will not be replaced for purchases made by any of the following:
 - Me
 - An authorized buyer
 - An alternate payee
 - Any other person to whom I voluntarily give my QUEST card and personal identification number (PIN)

- If any QUEST card on my account is lost or stolen, I may have to pay a \$2.70 fee to replace it. This fee will come out of my FoodShare benefits.

Note: Your signature below must be witnessed. Two witness signatures are required if you sign with an X.

SIGNATURE – Primary Cardholder or Other Authorized Person	Date Signed
SIGNATURE – Witness 1 (Required)	Date Signed
SIGNATURE – Witness 2*	Date Signed

*Required only if primary cardholder or other authorized person signed with an X.

Note: You have the right to have another person represent you and act on your behalf to complete the application/renewal process. This person will act as your authorized representative. If you wish to authorize someone to act on your behalf, complete the Medicaid /BadgerCare Plus/FoodShare Authorization of Representative form (F-10126). To get this form, contact your agency or visit www.dhs.wisconsin.gov/library/F-10126.htm.

For Income Maintenance (IM) Agency Caseworker Use Only

- New Authorized Buyer
 New Alternate Payee
 Remove Authorized Buyer
 Remove Alternate Payee

SIGNATURE – IM Agency Caseworker	Date Signed
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DISTRIBUTION: Case File – Original Member – Copy

USDA Nondiscrimination Statement
Do Not Send Applications Here

In accordance with federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, this institution is prohibited from discriminating on the basis of race, color, national origin, sex (including gender identity and sexual orientation), religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity.

Program information may be made available in languages other than English. Persons with disabilities who require alternative means of communication to obtain program information (e.g., Braille, large print, audiotape, American Sign Language), should contact the agency (state or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339.

To file a program discrimination complaint, a Complainant should complete a Form AD-3027, USDA Program

Discrimination Complaint Form which can be obtained online at: <https://www.usda.gov/sites/default/files/documents/ad-3027.pdf>, from any USDA office, by calling (833) 620-1071, or by writing a letter addressed to USDA. The letter must contain the complainant's name, address, telephone number, and a written description of the alleged discriminatory action in sufficient detail to inform the Assistant Secretary for Civil Rights (ASCR) about the nature and date of an alleged civil rights violation. The completed AD-3027 form or letter must be submitted to:

1. **mail:**
 Food and Nutrition Service, USDA
 1320 Braddock Place, Room 334
 Alexandria, VA 22314; or
2. **fax:**
 (833) 256-1665 or (202) 690-7442; or
3. **email:**
FNCSIVILRIGHTSCOMPLAINTS@usda.gov

This institution is an equal opportunity provider.
Do Not Send Applications Here