STUART T. WILSON CPA, PC
Fiscal Intermediary

New Participant Information

Submit completed form: setup@stuartwilsonfi.com
Fax: 989-832-5404

Host Agency Information Date of Referral: _____

Name of Host Agency: _____ Phone: _____

Agency Contact Name: _____ Email: _____

Fax: _____

Participant Information Type of Service: ☐ CLS ☐ Respite ☐ POS

First Day of Service: ____/__/_____

☐ **New Intake** ☐ **Transfer** If yes, Previous FI: _____ Existing EIN: ___-_____

Name: _____ Social Security: _____-_____-_____

Date of Birth: _____/_____/_____ Gender: ☐ Male ☐ Female

Street Address: _____ Email: _____

City: _____ State: MI Zip: _____ Phone: _____

Number of Employees: _____ Authorized Hours _____ ☐ Week ☐ Month

Contact (Payroll Questions/Reports): ☐ Participant ☐Guardian/Representative

Natural Supports

Legal Guardian: ☐ Yes ☐ No **Authorized Representative:** ☐ Yes ☐ No

Name: _____ Phone: _____

Street Address: _____ Email: _____

City: _____ State: ____ Zip: _____ Relationship:_____

Internal Office Use

Client #: Field Representative:

EIN#: Enrollment Meeting Date:

Ck#

Revised 2/2019