



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: <input type="checkbox"/> CLS <input type="checkbox"/> Respite <input type="checkbox"/> POS
		First Day of Service: ____/____/____
<input type="checkbox"/> New Intake <input type="checkbox"/> Transfer If yes, Previous FI: _____		Existing EIN: ____ - ____ - ____
Name: _____	Social Security: ____ - ____ - ____	
Date of Birth: ____/____/____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Street Address: _____	Email: _____	
City: _____	State: <u>MI</u>	Zip: _____ Phone: _____
Number of Employees: _____	Authorized Hours _____	<input type="checkbox"/> Week <input type="checkbox"/> Month
Contact (Payroll Questions/Reports): <input type="checkbox"/> Participant <input type="checkbox"/> Guardian/Representative		
Natural Supports		
Legal Guardian: <input type="checkbox"/> Yes <input type="checkbox"/> No		Authorized Representative: <input type="checkbox"/> Yes <input type="checkbox"/> No
Name: _____	Phone: _____	
Street Address: _____	Email: _____	
City: _____	State: ____	Zip: _____ Relationship: _____
Internal Office Use		
Client #:	Field Representative:	
EIN#:	Enrollment Meeting Date:	
Ck#		