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: _____

Type of Service: ☐ CLS ☐ Respite ☐POS

Participant Information ☐ **New Intake** ☐ **Transfer** If yes, Previous FI: _____

Medicaid ID:_____ 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 $_____/hr

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:_____

Communication Preferences

How would this person like to receive paperwork? Check all that apply. If mailing paperwork, note Address Type.

Email ☐

Mail ☐

How would this person like to receive alerts? Check all that apply. If they would prefer a text message, note phone type.

Phone Call ☐

Text Message ☐

Email ☐

Enrollment Meeting date: