MCFI Fiscal Agent Authorization

_____ County

Effective Date of Authorization:	

County:		Service Coordinator:	
		Phone Number:	

Client Name:		Payee's Name:	
Client Address:		Payee's Relationship:	
Client SSN			
Client Phone Number			

Provider Name:		Provider Name:	
Phone Number:		Phone Number:	
Hourly Wage:		Hourly Wage:	
Relationship to Client		Relationship to Client	

Provider Name:		Provider Name:	
Phone Number:		Phone Number:	
Hourly Wage:		Hourly Wage:	
Relationship to Client		Relationship to Client	

Provider Name:		Provider Name:	
Phone Number:		Phone Number:	
Hourly Wage:		Hourly Wage:	
Relationship to Client		Relationship to Client	

Provider Name:		Provider Name:	
Phone Number:		Phone Number:	
Hourly Wage:		Hourly Wage:	
Relationship to Client		Relationship to Client	

Funding Source (Please Check One)		Monthly Authorized Amount
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Cost Share:	
Amount:	
Effective Date:	
Deduct From Provider:	

Employer signature Date

Case Worker Date

Case Worker Phone # _____