FISCAL AGENT AUTHORIZATION FORM

_________ *County Human Services Department*

CLIENT/EMPLOYER INFORMATION

Client/Employer Name: ______________________________

Street Address: ______________________________

City/State/Zip: ______________________________

Social Security #: ______________ *Date of Birth:* ______________

Phone Number: ______________ *Service/Funding:* ______________

ACTION/AUTHORIZATION

☐ Opening ☐ Change ☐ Closing **Effective Date:** ______________

Reason/Rationale for Change or Closing: ______________________________

Case Manager: ______________ *C.M. #:* ________ *Telephone:* ______________

TOTAL MAXIMUM AUTHORIZED MONTHLY PAYMENTS: ______________

Authorization is per client/employer, not per employee

PROVIDER/EMPLOYEE INFORMATION

Employee Name: ______________________________

Street Address: ______________________________

City/State/Zip: ______________________________

Social Security #: ______________ *Date of Birth:* ______________

Phone Number: ______________ *Relationship to Client:* ______________

Rate of Pay: ______________ *Authorized # Units:* ______________

Provider Training Status: ☐ has training ☐ exempt ☐ Needs training

Comments on Training Status: ______________________________

SIGNATURES OF PARTIES

By signatures below, it is understood that all information presented on this form is true and complete; that services have been agreed to as presented; and that the service recipient (the client) is the employer.

Employer/Client:
(Please note relationship, i.e. guardian/parent) ______________________________ *date:* ______________

Employee/Provider: ______________________________ *date:* ______________

Case Manager: ______________________________ *date:* ______________

Supervisor: ______________________________ *date:* ______________

Original to MCFI; copy to County Fiscal Unit; copy in client chart; copies to employer & employee as needed.