STUART T. WILSON CPA, PC

CERTIFIED PUBLIC ACCOUNTANT
FISCAL INTERMEDIARY

TRANSFER:__Yes__No If Yes, from whom:

Organization:

Type of Service: **CLS:** ☐ **Respite:** ☐ **POS:** ☐

Start Date of Service:

Participant Information:

Name: Social Security #:

Address: Birthdate:

City: MI Zip Code: Phone:

***Supports Coordinator:** Estimated number of employees: Full time ______ Part Time ________

History of violence ___yes ___no **Gender: Male** ☐ **Female** ☐

Guardian/Family Contact Information:

Name: Phone #:

Address:

City: MI Zip Code:

Reports go to : ☐ Participant ☐ Parent/Guardian ☐ Email ☐ Mail ☐ SC

Supports Coordinator Information:

Name: **Email:**

Phone #: **Fax:**

Case Management Agency:

Address:

City: **MI** **Zip Code:**

Internal Office Use

Client #:

EIN#:

Ck#:

Supports Coordinator Complete Below:

Client#:

Set-up By: