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.