

PARTICIPANT INFORMATION

NAME: _____

ADDRESS: _____

City: _____ **State:** _____ **Zip Code** _____

Landline Number: _____

Cell Phone Number: _____

Date of Birth: _____

Social Security Number: _____

Host Agency: ___ **MI Choice Self Determined** ___ **AAA Purchase of Service**

___ **Veterans Administration** ___ **UPHP C-Waiver** ___ **UPHP ADHH**

UPCAP Care Manager: _____

Care Manager Phone Number: _____

Guardian if any: _____

Guardian Telephone Number: _____

Designated Representative if any: _____

Designated Representative Telephone Number: _____

Start Date (M/D/YEAR) _____

Employee Names: _____

Employees Switching over from DHS **Yes** **No**

Hours _____ **Weekly / Monthly** **Rate of pay** _____