STUART T. WILSON, CPA PC

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Organization: Shiawassee Health and Wellness

Type of Service: CLS ☐ Respite ☐ Purchase of Service: ☐

Start date for services: _____

Participant Information

Name: _____ Social Security #: _____

Address: _____ Birth date: _____

City: _____, MI Zip Code: _____ Phone #: (____) _____

Email: _____ Gender: Male ☐ Female ☐

Worker's Compensation Information:
***Supports Coordinator:** Estimated number of employees: Full-Time ☐ Part-Time ☐
History of Violence? Yes ☐ No ☐

Guardian/Family Contact Information

Name: _____ Social Security #: _____

Address: _____ Birth date: _____

City: _____, MI Zip Code: _____ Phone #: (____) _____

Email: _____

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

Supports Coordinator Information

Name: _____ Email: _____

Phone #: (___) _____ Fax #: (___) _____

Case Management Agency: _____

Address: _____

City: _____, MI Zip Code: _____

Internal Office Use:
Client #: _____ ID #: _____

EIN: _____ Set up by: _____

CK #: _____