ALLELUIA

Financial Management System
Enrollment Form

Participant Name: _____UCI# _____DOB: _____ Gender: _____

Address: _____City/State/Zip: _____

Email: _____Phone number: _____

☐ Individual receiving FMS service is their own representative

SDP Managing Party: _____ Relationship to Participant: _____

Address: _____City/State/Zip: _____

Email: _____Phone number: _____

If Participant is over 18 years of age/Conserved: ☐ Yes. ☐ No

Conservator/Parent Name: _____

Email: _____Phone number: _____

Regional Center: _____ Service Coordinator: _____

Is the Participant using an Independent Facilitator: ☐ Yes, ☐ No

Independent Facilitator: _____Phone: _____

Email: _____

Anticipated SDP Start date: _____

FMS Model Type: ☐ Bill payer ☐ Co-Employer ☐ Sole Employer

Is your budget certified? _____What is the budget total? _____

Do you have a completed spending plan? _____

Number of Employees to Onboard (if known): _____