



MY CHOICE FAMILY CARE WORKER SET-UP FORM

Instructions: Please fill out any information in Sections 1 and 2, where applicable. Both the worker and the participant, or the participant's representative (Legal Guardian or POA), must sign and date the bottom in order to be considered complete. Please submit the completed form to **Premier Financial Management Services (PFMS)** via one of the following options below:

Mail:
PO Box 26001
Milwaukee, WI 53226

Drop Off:
10425 W North Ave.
Suite 345
Milwaukee, WI 53226

Email:
MCFCC@premier-fms.com

Fax:
1-855-712-7113

WORKER'S INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Work #: _____

Email Address: _____

Date of Birth: ____ / ____ / _____ Social Security Number: _____

PARTICIPANT'S INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____ Work #: _____

Email Address: _____

Date of Birth: ____ / ____ / _____

By signing below, you certify that the information on this form is accurate and that you have all supporting documentation that may be needed to verify your selection.

Worker Signature: _____ Date: ____ / ____ / _____

Participant Signature: _____ Date: ____ / ____ / _____