INDEPENDENCE CENTER – COLORADO VETERAN DIRECTED CARE AUTHORIZED REPRESENTATIVE FORM

Instructions: Please fill out any information in Sections 1 and 2, where applicable. Veterans are required to sign and date at the bottom of the form. If a Veteran has an Authorized Representative, the AR must also sign and date the form. Please submit the completed form to PremierFMS via one of the following options:

Mail	**Email**	**Fax**
10425 W North Ave Suite 345 Milwaukee, WI 53226	ICVIC@Premier-FMS.com	855.325.4668

SECTION 1: VETERAN'S INFORMATION

______________________ ___________ __________________________
First Name Middle Initial Last Name

____________________________ _______________ ________ ________
Mailing Address City State Zip

____________________ ____________________ ____________________
Home Phone Mobile Phone Work Phone

____
Email Address

______ / ______ / ________ __________ - ______ - _________
Date of Birth Social Security Number

SECTION 2: AUTHORIZED REPRESENTATIVE'S INFORMATION

(If applicable)

First Name ____________ Middle Initial ____________ Last Name ____________

Mailing Address ____________ City ____________ State ____________ Zip ____________

Home Phone ____________ Mobile Phone ____________ Work Phone ____________

Email Address ____________

____ / ____ / ______ Date of Birth

______ - ____ - ______ Social Security Number

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. For any questions or concerns, please contact our office at **855.275.3948**.

Veteran Signature ____________ Date ____________

Authorized Representative Signature ____________ Date ____________