



Financial Management Services

PCA, Elder, MFP, ABI Programs: PO Box 479 East Windsor, CT 06088-0479

Phone: 860-627-9500 Toll Free: 877-722-8833

Fax: 860-627-0230

DDS & Alabama Programs: PO Box 509 East Windsor, CT 06088-0509

Phone: 860-627-9500 Toll Free: 866-275-1358

Fax: 860-627-0330 Toll Free Fax: 866-598-2227

www.acrfi.org

"Creating Opportunities for People"

REPRESENTATIVE DOCUMENTATION

Date: \_\_\_\_\_

I, \_\_\_\_\_, give Allied permission to speak with my representative (Consumer/Employer)

\_\_\_\_\_, about my plan with the following access:

(Please check all that apply)

- NO RESTRICTIONS (full disclosure; all permissions below)
May speak of contents of plan
May discuss payroll issues
May discuss adjustments to household providers
May speak about timesheets
May speak about employees
May pick up checks
May request checks mailed to their house (see address below)
Other Restrictions or Access

Consumer/Employer Signature: \_\_\_\_\_ Date \_\_\_\_\_

IMPORTANT NOTE: All information is required for this document to be valid. Please complete all areas of the form. If you are a Legal Guardian, Conservator, Power of Attorney, etc. legal documentation MUST be attached to this completed document.

Representative Name: \_\_\_\_\_

(Please check all that apply)

- Legal Guardian, Conservator, Power of Attorney, N/A

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone (required): (\_\_\_\_\_) \_\_\_\_\_

Representative Signature: \_\_\_\_\_

(For office use only) Program: \_\_\_PCA \_\_\_ABI \_\_\_Elder \_\_\_DDS \_\_\_ALA