APPLICATION TO BE AUTHORIZED TO SIGN VENDOR AGREEMENTS AND PAYMENT REQUEST FORMS WHEN THERE IS NO EMPLOYER OF RECORD

Supports Waiver and Mi Via PARTICIPANTS ONLY

The Supports Waiver and Mi Via Program allows a participant or his/her authorized representative to sign Vendor Agreements and Payment Request Forms (PRF) for vendor payments without having to go through the Employer of Record (EOR) enrollment process under the following circumstances:

1) All Supports Waiver and Mi Via service providers **must** be vendors. If employees are currently providing services, they will need to be terminated before this form can take effect.
2) If the participant is to be the one authorized to sign the Vendor Agreements and PRF's, the participant must be at least 18 years of age, and cannot have an authorized representative over financial matters (for example a court-appointed legal guardian, a conservator over financial matters, or a person acting under the authority of a valid power of attorney) ; or
3) If an authorized representative is to be the one authorized to sign Vendor Agreements and PRF's, a "Self-Direction Appointment of Authorized Representative" form must be completed, and the authorized representative cannot be a paid provider of Supports Waiver and Mi Via Services for the participant.

Please complete **A** if the participant is applying to be authorized to sign Vendor Agreements and PRF's.

A. Print Participant Name_____ Medicaid ID #_____

Address and Phone Number_____

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By signing this form, I attest that I do not have an authorized representative over financial matters. I also understand that all my providers must be vendors. I understand that if I currently have employees providing Supports Waiver or Mi Via services to me, they must be terminated.

Participant Signature_____ Date_____

Please complete **B** if the participant's Authorized Representative is applying to be authorized to sign Vendor Agreements and PRF's and submit the Self-Direction Appointment of Authorized Representative form with this form.

B. Print Participant Name_____ Medicaid ID#_____

Print Authorized Representative Name_____

Authorized Representative Address and Phone Number_____

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By signing this form, I attest that I am not a paid provider of Supports Waiver or Mi Via services for the participant. I also understand that all the participant's providers must be vendors. I understand that if there currently are employees providing Supports Waiver or Mi Via services to the participant, they must be terminated.

Authorized Representative Signature_____ Date_____