Acumen Fiscal Agent
Innovation • Opportunity • Freedom

FAMILY CARE CHANGE INFORMATION FORM: MEMBER & REPRESENTATIVE

Please complete this form and return to Acumen by one of the following methods:
Mail: 5416 E. Baseline Road, Suite 200, Mesa, AZ 85206
Fax: 800-687-3121
Email: Wisconsin@acumen2.net

Change MEMBER/EMPLOYER Information

Complete this section when there is a change in the member's information. The member employer is the individual receiving services. For a name change, provide the previous name, new name, and attach a legal document supporting the name change.

Change In (select all that apply): Name ☐ Address ☐ Phone Number ☐ Email Address ☐	
Current/Previous Name:	New Name (if changed):
Street Address:	
City/State/Zip:	
Phone Number:	
Email Address:	Client ID Number:
Signature (Employer or Authorized Rep):	
Date:	

Change GUARDIAN/POA/AUTHORIZED REPRESENTATIVE Information

Complete this section when there is a change in the guardian, POA, or authorized representative's information. The guardian/POA/authorized representative is the one that assists the member with or completes hiring, training, and managing staff. For a name change, provide the previous name, new name, and attach a legal document supporting the name change.

Change In (select all that apply): Name ☐ Address ☐ Phone Number ☐ Email Address ☐	
Current/Previous Name:	New Name (if changed):
Street Address (if changed):	
City/State/Zip (if changed):	
Phone Number (if changed):	
Email Address:	Client ID Number:
Signature (Employer or Authorized Rep):	
Date:	