

Designation of Surrogate Employer

Check this box if this form is being used to change the Employer of Record on an existing participant's account. Date the change requested: ____/____/____. This change will be effective starting the next scheduled service period after paperwork is processed.

PARTICIPANT INFORMATION		
Full Name	ID / Last 4 of SSN	Program <input type="checkbox"/> WORK

The employer of record will manage and direct the services and funds provided under the budget. This may include either agency-provided, agency-directed employer of record or member-directed attendant care. The tasks may include recruiting, hiring, training, and terminating caregivers who provide support to the participant, overseeing worker tasks and schedules, completing enrollment forms, and submitting timesheets. Tasks may also include directing budgeted funds to providers or vendors the participant chooses to use. The employer of record functioning, must be over the age of 18, demonstrate a strong commitment to the participant, display knowledge about and respect for the participant's preferences, and use sound judgment to act on the participant's behalf.

EMPLOYER INFORMATION			
First Name	Middle Name	Last Name	
Social Security Number	Email	Date of Birth (mm/dd/yyyy)	
Relationship to Participant <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Other Non-relative <input type="checkbox"/> Other: _____			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Physical Address (Street Address, Including Apt. #)			
City	State	Zip	County
Mailing Address (Street Address, Including Apt. #) – <i>if different than the physical address</i>			
City	State	Zip	County
Phone1	Phone2	Preferred Method of Communication <input type="checkbox"/> Email <input type="checkbox"/> Mail <input type="checkbox"/> Phone / Voicemail	

The employer does not receive monetary compensation for directing care on the participant's behalf in the course of the self-directed program. Employers cannot provide direct support services to the participant. Employees must have no convictions involving exploitation, abuse, or assault on another person and must be fully capable of the responsibilities associated with managing support staff and handling financial aspects of the self-directed program, including proper utilization of the budget and verifying the accuracy of reports provided by Palco.

By completing this form and signing below, all parties agree that the individual named herein shall accept the responsibilities of the employer of record. The employer consents to complete enrollment electronically and has provided an email address and Social Security Number that belongs to him and her. The employer understands that Palco is not responsible for providing information to an incorrect email address supplied by him or her. The employer has read and agrees to Palco's Notice of Privacy Practices and the Terms and Conditions of Palco's online enrollment system and agrees to receive information, notifications, and other correspondence electronically to the email address provided in this document. Such correspondence may contain Personal Health Information as defined at 45 CFR 160.103 and other personally identifiable information. The employer accepts all risks associated with the transmission of such information via those channels. The employer understands that his or her consent is in effect until Palco is notified in writing that the employer withdraws such consent.

Employer Printed Name

Participant Printed Name

Employer Signature

Participant Signature

Date

Date

*If the participant is unable to sign,
please witness:*

Witness Printed Name

Witness Signature

Date