

Point of Contact Form (Optional)

Participant Information

UCI Number # _____ DOB ____/____/____

Last Name _____ First Name _____ M.I. _____

Signature of Employer or Participant _____ Date _____

Point of Contact

Please circle either **YES** or **NO** which indicates your agreement with and acknowledgement of the following:

1. I understand that I may designate a non-family member to assist me in my self direction responsibilities to the extent that I prefer. This designee may not act as either my employee or my independent contractor.

I may change my mind and revoke my choice at any time by notifying Public Partnerships LLC, my fiscal employer agent.

2. I wish designate a non-family member to assist me in the Golden Gate Regional Center program with PPL.

I have discussed the specific assistance I would like from my designee. I give my permission for members of the PPL team to contact my designee listed below:

If you wish to allow PPL to discuss your services and program information with a non-family member designee, please provide the following information:

Last Name _____ First Name _____ M.I. _____

Phone (____) _____ Email _____

Relation to the Employer _____

I agree to act as an additional point of contact for the Participant in the PPL FMS program:

Non-Family Member Designee's Signature _____

Date _____

*Please note: This is an **OPTIONAL** form. This form is only required if an individual other than the Employer will be assisting with Employer responsibilities*

Phone (English) (877)-522-1053

Administrative Fax: (855)-867-1676

Phone (Cantonese) (877)-522-1055

TTY: (800)-360-5899

Phone (Spanish) (877)-522-1054

Email: CAGGRC@pcgus.com

Web: www.publicpartnerships.com