

NJ EMPLOYER WITH EMPLOYEES AND VENDORS PACKET RESOURCE

A large yellow five-pointed star with a black outline, positioned below the blue header box.

**ELECTRONIC
SIGNATURES
ACCEPTED
ON ALL FORMS**

EMPLOYER PACKET

**ELECTRONIC
SIGNATURES
ACCEPTED
ON ALL FORMS**

****BLUE = REQUIRED FIELD**

****ORANGE – IF APPLICABLE**



Authorization Form

Complete each item and fax 866-486-4179 or mail 5416 E Baseline Rd., Suite 200, Mesa, AZ 85206 to Acumen. Please call 833-892-0413 if you have any questions.

I hereby authorize Acumen Fiscal Agent (Acumen) to:

1. File Form SS-4 on my behalf to obtain an Employer Identification Number (EIN), if I do not already have one, and allow the IRS to mail EIN information to Acumen once obtained. **Note: If you currently have or have had an EIN, please contact the above phone number before proceeding with the employer enrollment paperwork.**
2. Represent me as an employer for employer-related tax reporting purposes, by signing Form 2678.
3. Handle all correspondence regarding employer tax reporting issues.
4. Serve as my Full Service Agent for unemployment and withholding tax purposes. As such, Acumen shall provide all services for me, the employer, (tax, benefits, and appeals) and shall receive all documents related to my, the employer's, New Jersey unemployment and withholding tax account that would otherwise have been sent to me.
5. Receive confidential information and perform any and all acts the employer can perform relating to matters pertaining to New Jersey's unemployment compensation law and state tax withholding regulations effective signature date forward, subject to revocation.
6. Electronically send me (e.g. e-mail) information including, but not limited to: employer and/or employee enrollment information, account statement reports, good-to-go information, and new products or services.

Any limitations to this authorization must be specifically stated and attached. This authorization revokes all earlier authorizations and powers of attorney on file and shall remain in effect until receipt of a written notice of revocation or a subsequent authorization or power of attorney by the New Jersey Department of Treasury and/or New Jersey Department of Labor & Workforce Development.

What am I really authorizing?

- Your appointment grants Acumen Fiscal Agent a limited power of attorney to act as your agent for acts required under IRS Section 3504 & Tres. Reg 31.3504.
- You are appointing Acumen Fiscal Agent to act as your agent for the New Jersey Department of Treasury and New Jersey Department of Labor & Workforce Development in the fulfilling of domestic employer responsibilities relative to the employing of persons through initiatives funded by the State of New Jersey, Department of Developmental Disabilities (DDD) division.

Employer

The person who hires, fires, trains and manages staff.

Name:	EMPLOYER NAME
Social Security Number:	EMPLOYER SSN
Street Address:	EMPLOYER ADDRESS
City/State/Zip:	CITY/STATE/ZIP
Mailing Address (if different):	MAILING ADDRESS
City/State/Zip (if different):	CITY/STATE/ZIP
County of Residence:	COUNTY
Phone Number:	PHONE NUMBER
E-mail Address :	EMAIL ADDRESS

Individual

The individual receiving services.

Name:	CLIENT NAME
Date of Birth:	CLIENT DOB
Physical Address (if different):	CLIENT ADDRESS
City/State/Zip (if different):	CITY/STATE/ZIP

Support Coordinator

Name:	SC NAME
E-mail Address:	SC EMAIL
Phone Number:	SC PHONE NUMBER

Your signature means that you have read and understand the above information.

Signature:	EMPLOYER SIGNATURE	Date:	MM/DD/YYYY
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Form **2678** **Employer/Payer Appointment of Agent**

(Rev. December 2023) Department of the Treasury — Internal Revenue Service

OMB No. 1545-0748

Use this form if you want to request approval to have an agent file returns and make deposits or payments of employment or other withholding taxes or if you want to revoke an existing appointment.

- If you're an employer or payer who wants to request approval, complete Parts 1 and 2 and sign Part 2. Then give it to the agent. Have the agent complete Part 3 and sign it.

Note: This appointment isn't effective until we approve your request. See the instructions for more information.

- If you're an employer, payer, or agent who wants to revoke an existing appointment, complete all three parts. In this case, only one signature is required.

Part 1: Why you're filing this form.

(Check one)

- ☒ You want to **appoint** an agent for tax reporting, depositing, and paying.
☐ You want to **revoke** an existing appointment.

Part 2: Employer or Payer Information: Complete this part if you want to appoint an agent or revoke an appointment.

1 Employer identification number (EIN)

X X - X X X X X X X X

→ **2 Employer's or payer's name**
(not your trade name)

EMPLOYER NAME

3 Trade name (if any)

→ **4 Address**

EMPLOYER ADDRESS

Number Street Suite or room number

CITY

ST

ZIP

City

State

ZIP code

Foreign country name

Foreign province/county

Foreign postal code

5 Forms for which you want to appoint an agent or revoke the agent's appointment to file. (Check all that apply.)

Form 940, Employer's Annual Federal Unemployment (FUTA) Tax Return* (all 940 series)

Form 941, Employer's QUARTERLY Federal Tax Return (all 941 series)

Form 943, Employer's Annual Federal Tax Return for Agricultural Employees (all 943 series)

Form 944, Employer's ANNUAL Federal Tax Return (all 944 series)

Form 945, Annual Return of Withheld Federal Income Tax

Form CT-1, Employer's Annual Railroad Retirement Tax Return

Form CT-2, Employee Representative's Quarterly Railroad Tax Return

For ALL
employees/
payees/payments

For SOME
employees/
payees/payments

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* Generally, you can't appoint an agent to report, deposit, and pay tax reported on Form 940, unless you're a home care service recipient.

- ☒ Check here if you're a home care service recipient, and you want to appoint the agent to report, deposit, and pay FUTA tax for you. See the instructions.

I am authorizing the IRS to disclose otherwise confidential tax information to the agent relating to the authority granted under this appointment, including disclosures required to process Form 2678. The agent may contract with a third party, such as a reporting agent or certified public accountant, to prepare or file the returns covered by this appointment, or to make any required deposits and payments. Such contract may authorize the IRS to disclose confidential tax information of the employer/payer and agent to such third party. If a third party fails to file the returns or make the deposits and payments, the agent and employer/payer remain liable.

X Sign your name here

EMPLOYER SIGNATURE

Print your name here

EMPLOYER NAME

Print your title here

HCSR EMPLOYER

→ Date

MM / DD / YYYY

Best daytime phone

PHONE

Now give this form to the agent to complete.

For Privacy Act and Paperwork Reduction Act Notice, see the separate instructions. www.irs.gov/Form2678

Cat. No. 18770D

Form **2678** (Rev. 12-2023)

****BLUE = REQUIRED FIELD**

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SS-4 Form (Rev. December 2023) Department of the Treasury Internal Revenue Service		Application for Employer Identification Number (For use by employers, corporations, partnerships, trusts, estates, churches, government agencies, Indian tribal entities, certain individuals, and others.) See separate instructions for each line. Keep a copy for your records. Go to www.irs.gov/FormSS4 for instructions and the latest information.		OMB No. 1545-0003
			EIN	EIN
1 Legal name of entity (or individual) for whom the EIN is being requested EMPLOYER NAME				
2 Trade name of business (if different from name on line 1)		3 Executor, administrator, trustee, "care of" name		
4a Mailing address (room, apt., suite no. and street, or P.O. box) 5416 E BASELINE RD STE 200		5a Street address (if different) (Don't enter a P.O. box.) EMPLOYER ADDRESS		
4b City, state, and ZIP code (if foreign, see instructions) MESA, AZ 85206-4704		5b City, state, and ZIP code (if foreign, see instructions) CITY/STATE/ZIP		
6 County and state where principal business is located COUNTY/STATE				
7a Name of responsible party EMPLOYER NAME		7b SSN, ITIN, or EIN SSN		
8a Is this application for a limited liability company (LLC) (or a foreign equivalent)? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		8b If 8a is "Yes," enter the number of LLC members		
8c If 8a is "Yes," was the LLC organized in the United States? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
9a Type of entity (check only one box). Caution: If 8a is "Yes," see the instructions for the correct box to check. <input type="checkbox"/> Sole proprietor (SSN) <input type="checkbox"/> Estate (SSN of decedent) <input type="checkbox"/> Partnership <input type="checkbox"/> Plan administrator (TIN) <input type="checkbox"/> Corporation (enter form number to be filed) <input type="checkbox"/> Trust (TIN of grantor) <input type="checkbox"/> Personal service corporation <input type="checkbox"/> Military/National Guard <input type="checkbox"/> State/local government <input type="checkbox"/> Church or church-controlled organization <input type="checkbox"/> Farmers' cooperative <input type="checkbox"/> Federal government <input type="checkbox"/> Other nonprofit organization (specify) <input type="checkbox"/> REMIC <input type="checkbox"/> Indian tribal governments/enterprises <input checked="" type="checkbox"/> Other (specify) HCSR EMPLOYER Group Exemption Number (GEN) if any				
9b If a corporation, name the state or foreign country (if applicable) where incorporated		State		Foreign country
10 Reason for applying (check only one box) <input type="checkbox"/> Started new business (specify type) <input type="checkbox"/> Banking purpose (specify purpose) <input type="checkbox"/> Hired employees (Check the box and see line 13.) <input type="checkbox"/> Changed type of organization (specify new type) <input type="checkbox"/> Compliance with IRS withholding regulations <input type="checkbox"/> Purchased going business <input checked="" type="checkbox"/> Other (specify) HCSR EMPLOYER <input type="checkbox"/> Created a trust (specify type) <input type="checkbox"/> Created a pension plan (specify type)				
11 Date business started or acquired (month, day, year). See instructions.		12 Closing month of accounting year DECEMBER		
13 Highest number of employees expected in the next 12 months (enter -0- if none). Agricultural Household Other 0		14 Reserved for future use		
15 First date wages or annuities were paid (month, day, year). Note: If applicant is a withholding agent, enter date income will first be paid to nonresident alien (month, day, year).				
16 Check one box that best describes the principal activity of your business. <input type="checkbox"/> Health care & social assistance <input type="checkbox"/> Wholesale-agent/broker <input type="checkbox"/> Construction <input type="checkbox"/> Rental & leasing <input type="checkbox"/> Transportation & warehousing <input type="checkbox"/> Accommodation & food service <input type="checkbox"/> Wholesale-other <input type="checkbox"/> Retail <input type="checkbox"/> Real estate <input type="checkbox"/> Manufacturing <input type="checkbox"/> Finance & insurance <input checked="" type="checkbox"/> Other (specify) HCSR EMPLOYER				
17 Indicate principal line of merchandise sold, specific construction work done, products produced, or services provided. HCSR EMPLOYER				
18 Has the applicant entity shown on line 1 ever applied for and received an EIN? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If "Yes," write previous EIN here				
Third Party Designee	Complete this section only if you want to authorize the named individual to receive the entity's EIN and answer questions about the completion of this form.			
	Designee's name ALMA STEWART, SUNNY HUDSON		Designee's telephone number (include area code) (623) 792-6100	
	Address and ZIP code 5416 E BASELINE RD STE 200, MESA, AZ 85206-4704		Designee's fax number (include area code) (480) 371-2241	
Under penalties of perjury, I declare that I have examined this application, and to the best of my knowledge and belief, it is true, correct, and complete.				
Name and title (type or print clearly) EMPLOYER NAME		HCSR EMPLOYER		PHONE NUMBER
Signature EMPLOYER SIGNATURE		Date MM/DD/YYYY		Applicant's fax number (include area code) EMPLOYER FAX NUMBER

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 16095N

Form **SS-4** (Rev. 12-2023)

****BLUE = REQUIRED FIELD**

****ORANGE – IF APPLICABLE**



M-5008-R
(5/24)

New Jersey Division of Taxation
Appointment of Taxpayer Representative

1. Taxpayer Information

Use this form to designate a representative(s) and grant the representative(s) the authority to obligate, bind, and/or appear on your behalf before the New Jersey Division of Taxation. Section 3 of the form allows you to list which tax matters your representative is authorized to handle on your behalf.

Taxpayer is:

- ☐ Individual ☐ Corporation ☒ Sole Proprietorship ☐ Limited Liability Company
☐ Estate ☐ Partnership ☐ Trust (other than a business trust)
☐ Other Specify _____

Taxpayer's Name (Unitary Group Name if combined group) EMPLOYER NAME		SS Number/NJ Taxpayer ID Number/Unitary ID Number	
Spouse's/CU Partner's Name		Social Security Number EMPLOYER SSN	
Mailing Address EMPLOYER MAILING ADDRESS		Country (If not US)	
City CITY	State STATE	ZIP Code ZIP CODE	
Email Address EMPLOYER EMAIL		Phone Number PHONE NUMBER	
Managerial Member's Name (if combined group)		Managerial Member's FEIN	
Name of Trustee or Executor			
Address of Trustee or Executor		Country (If not US)	
City	State	ZIP Code	
Email Address		Phone Number	

2. Representative Information

The named representative(s) must sign and date where indicated in Section 8 on page 2 or this appointment will be rejected. If the representative is a tax practitioner, the representative must enter his/her Preparer Tax Identification Number (PTIN) as the Representative ID. Representatives who do not have a PTIN must enter their Social Security number.

The taxpayer(s) named in Section 1 above appoints the person(s) named below as his/her/their taxpayer representative to represent them in connection with the tax matter(s) listed in Section 3.

Name Ricardo Resendiz		Representative ID P03344510	
Address 5416 E Baseline Rd #200, Mesa, AZ 85206			
Email Address Tax-NJ@Acumen2.net		Phone Number 623-792-6100	Fax Number 480-371-2241
Name Sunny Hudson		Representative ID P03299019	
Address 5416 E Baseline Rd #200, Mesa, AZ 85206			
Email Address Tax-NJ@Acumen2.net		Phone Number 623-792-6100	Fax Number 480-371-2241

3. Tax Matters

I/We appoint the representative(s) named in Section 2 above to represent me/us for:

- ☐ All tax matters ☒ Specific tax matters listed below

Type of Tax (New Jersey Gross Income, Sales and Use, Corporation, Partnership, Employment, Inheritance, etc.)	Years(s) and Period(s)
Employment	

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4. Acts Authorized

The representative(s) is/are authorized to receive and inspect confidential tax records and is/are granted full power to act with respect to the tax matters described in Section 3 above, and to do and perform all such acts as I/we could do or perform. The authority granted by this appointment does not include the power to endorse a refund check.

- ☐ If you want the representative(s) to have limited power, provide an explanation on the lines below and check this box. You may attach additional information as well.

5. Notices and Communications

We will send original notices and other written communications to you and a copy (other than automated computer notices) to the first representative listed in Section 2 unless you check one or more of the boxes below.

- ☐ I/We do not want the Division to send any notices or communications to my representative(s).
- ☐ I/We want the Division to send a copy of notices and/or communications (other than automated computer notices) to both representatives listed in Section 2.

6. Retention/Revocation of Prior Appointment(s) or Power(s)

The filing of this form automatically revokes all earlier Appointment(s) of Taxpayer Representative and/or Power(s) of Attorney on file with the Division of Taxation for the tax matters and years or periods listed in Section 3 unless you check the box below.

- ☐ I/We do not want to revoke any prior Appointment(s) of Taxpayer Representative and/or Power(s) of Attorney. If you check this box, you must attach copies of the previous Appointment(s) and/or Power(s) that you do not want to revoke.

7. Signature of Taxpayer(s)

If the tax matters covered by this appointment concern a joint Gross Income Tax return and the representative(s) is/are being appointed to represent both spouses/CU partners, both must sign below.

If a corporate officer, partner, guardian, tax matter partner, executor, administrator, or trustee signs the appointment on behalf of the taxpayer, the signature below certifies that they have the authority to execute this form on behalf of the taxpayer(s).

Note: If the taxpayer is a combined group, the managerial member is responsible for acting on behalf of the group for Corporation Business Tax purposes. The corporate officer of the managerial member who signs the appointment on behalf of the combined group certifies that they have the authority to execute this form on behalf of the combined group.

This Appointment of Taxpayer Representative Is Void if not Signed and Dated

Taxpayer Signature		EMPLOYER SIGNATURE	Date	MM/DD/YYYY
Print Name		EMPLOYER NAME	Title (if applicable) Domestic Employer	
Taxpayer Signature			Date	
Print Name			Title (if applicable)	

8. Acceptance of Representation and Signature

I/We accept the appointment as representative(s) for the taxpayer(s) who has/have executed this Appointment of Taxpayer Representative.

Representative Signature		Date
Print Name	Title (if applicable)	
Representative Signature		Date
Print Name	Title (if applicable)	



Employer's Previous Business Information

****BLUE = REQUIRED FIELD**
****ORANGE – IF APPLICABLE**
☐ SELECT ONE

This form must be completed by the individual assuming the role of the Employer. Please provide a response to every question below. If any of the questions *cannot* be answered, check "N/A" or write "Do not know" next to the question.

Please do not provide answers to the below questions based on a Partnership, Corporation, Limited Liability Company (LLC), Trust, Estate, Nonprofit or any other entity not considered a Sole Proprietor. Acumen Fiscal Agent, LLC can only accept an EIN and business information for a Sole Proprietor business. **If you have ever owned a Sole Proprietor (currently or in the past), you must let us know. Failure to do so will also drastically increase the time it takes to enroll and receive services under this program.**

Employer Full Name (as shown on Social Security Card) EMPLOYER NAME	Employer Social Security Number (SSN) EMPLOYER SSN
Other Names or Alias Used (please list all): EMPLOYER NAMES OR ALIAS USED	

	YES	NO	N/A
1. Have you ever received an Employer Identification Number (EIN) for any Sole Proprietor business you currently or have previously owned? If yes: Please provide the previously assigned Federal EIN: EMPLOYER EIN What was the nature of the business: NATURE OF BUSINESS Is the business still active (including any requirements for filing income tax, payroll tax, or information returns): YES <input type="checkbox"/> NO <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever previously been enrolled with another Fiscal/Employer Agent (F/EA), sometimes known as a Financial Management Service Agency? If yes: Please provide the name of the F/EA: F/EA Please provide dates of when you were with the F/EA: MM/DD/YYYY (FROM CALENDAR)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Was a business account ever established on your behalf for state unemployment insurance (SUTA) by your state's Department of Labor/Employment? If yes: Please provide the account number, if known: SUTA NUMBER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Was a business account for state income tax (SIT) withheld on behalf of your employees ever established on your behalf with the state's Department of Revenue? If yes: Please provide the account number, if known: SIT NUMBER	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered yes to question #2, please contact the prior F/EA to obtain the documents received from the Internal Revenue Service (IRS) and state taxing authorities when you were granted your EIN and state tax accounts. Documents should include a Letter 147C or CP575 issued by the IRS, and confirmation of the state tax accounts being created.

EMPLOYER SIGNATURE

MM/DD/YYYY

Employer Signature

Date

ACUMEN FISCAL AGENT LLC
5416 E BASELINE RD STE 200
MESA, AZ 85206
ENROLLMENT@ACUMEN2.NET

Rev. 10/2023

****BLUE = REQUIRED FIELD**

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New Jersey DDD SD Employer Agreement Form

This Agreement is between Acumen Fiscal Agent and the Employer as stated below.

- Participation in this Self Direction option is a decision I have made after consultation with my Support coordinator.
- I have received from my Support Coordinator any/all program related information about my service delivery options and the rules and regulations regarding my participation in the NJ DDD-SD program. I understand it is my responsibility as the Employer of Record to abide by all the rules and regulations of this program and the NJ DDD SD Individual Agreement I have signed.
- I understand that I am the Employer of Record for this program. The employer is not Acumen Fiscal Agent or the NJ DDD SD administrators. I understand that as the employer of record I am responsible to comply with paying all of my employees in accordance with the Department of Labor Regulations including the Fair Labor Standards Act and Final Rule. I understand that this employer responsibility may extend beyond what the program funds may pay my employee, and I accept full responsibility for all debts owed.
- I understand it is my responsibility to hire and train only qualified providers/workers, as defined by the NJ DDD SD policy manuals, to provide my services.
- I understand Acumen will provide me with enrollment materials and guidance on the requirements to complete each form. It is ultimately my responsibility as the employer to ensure all forms that my worker and/or I complete are correct within required guidelines.
- I will not allow provider(s)/worker(s) to begin performing work until Acumen has notified me that provider(s)/worker(s) are active in their system (Good to Go).
- I understand that Acumen is only authorized to represent me in processing payments as it relates to the NJ DDD-SD Program. Acumen will only make payments on my behalf in accordance to the authorized amounts as outlined in my approved annual amount.
- I understand it is my responsibility to be aware of any remaining balances and schedule provider(s)/worker(s) and/or request program payments within those available units and funds.
- I understand that if I cause work to happen above and beyond what is authorized in my Service Detail Report Budget, I as the employer, will be personally responsible for those expenses.
- I understand that, on occasion, I may receive automated (general announcement) communication from Acumen regarding important program and/or payroll information as it relates only and specifically to the NJ DDD SD Program.
- I understand it is my responsibility to notify my Support coordinator immediately of any significant changes in circumstances that may affect the individual's Service Detail Report/Budget and/or safety.

- I understand all requests for payment must be submitted through Acumen's online time entry system which requires password-protected employer approval, or paper timesheets which must be emailed or faxed by the payroll deadline. I understand that Acumen will not process a payment request without proper employer approval.
- I attest that I will submit and/or approve all payment requests in accordance with the Program regulations. I understand that payment and satisfaction of my claims may be from State funds, and that I may be prosecuted under applicable State laws, for any false claims, statements or documents or concealment of a material fact. Any misuse of funds may result in being fined or penalized including but not limited to the repayment of claim. Any collection costs or legal fees will be my responsibility to pay.
- I understand and approve photos being captured for the use of time entry and time validation. Photos are one method to verify the individual is present when the services are rendered.

My signature below confirms my understanding and agreement to abide by the terms and conditions as stated above.

Name of Individual: CLIENT NAME

Name of Employer/ Representative (if applicable): EMPLOYER NAME

Phone: (XXX) XXX-XXXX Email Address: EMPLOYER EMAIL

Individual or Employer/ Representative Signature: EMPLOYER SIGNATURE Date: MM/DD/YYYY

Acumen Fiscal Agent, LLC.
5416 E. Baseline Rd., Suite 200
Mesa, AZ 85206
Phone: 833-892-0413
Fax: 866-486-4179
enrollment@acumen2.net

****BLUE = REQUIRED FIELD**

****ORANGE – IF APPLICABLE**

**New Jersey Vendor
Community Vendor
Representative Agreement**



**Fiscal/Employer Agent
Authorized
Form**

This document is used to assign and gather demographic information about the Authorized Representative and is an agreement between that person and Acumen Fiscal Agent.

Name of Individual:	CLIENT NAME
I, Individual or Legal Guardian, CLIENT NAME hereby assign the person stated below as my Authorized Representative	
Authorized Representative Name:	AUTHORIZED REPRESENTATIVE NAME
Authorized Representative Mailing Address:	AUTHORIZED REPRESENTATIVE ADDRESS
Authorized Representative City/State/Zip:	CITY/STATE/ZIP CODE
Authorized Representative Phone Number:	AUTHORIZED REPRESENTATIVE PHONE
Authorized Representative Email Address:	AUTHORIZED REPRESENTATIVE EMAIL
Individuals Relationship to Authorized Representative:	CLIENT RELATIONSHIP TO AUTH. REP.

An Authorized Representative can be any person identified by the Individual or their legal guardian in consultation with the Support Coordinator to manage the duties within this program; when the Individual or their legal guardian is unable to do so independently.

An Authorized Representative must:

- Show a strong personal commitment to the Individual
- Show knowledge about the preferences of the Individual
- Agree to visit the Individual at least every pay period
- Be willing and able to meet all program requirements for the program
- Be at least 18 years old
- Be willing to submit to criminal background checks, if requested

An Authorized Representative may:

- Review, submit, and approve employee time to ensure accuracy
- Review, submit, and approve request for vendor time to ensure accuracy, if applicable
- Obtain confidential information from Acumen Fiscal Agent regarding their Individual; including, the authorization, payroll, etc.
- If applicable, perform employer related duties, such as but not limited to: assist in hiring and terminating employees, managing employees, completing forms, and managing the monthly authorization

An authorized Representative Cannot:

- Be paid for services in this program or be hired by the Individual as an employee
- Be known to conduct illegal activities
- Have any history of physical, mental or financial abuse

By signing below, I confirm that I have read this "Authorized Representative Form." I also confirm by signing below that I understand what is being required of me and agree to follow its terms and conditions. I am willing to volunteer to serve as the Authorized Representative without payment for the listed Individual.

Authorized Representative Signature: AUTHORIZED REP. SIGNATURE Date: MM/DD/YYYY

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SUPPORT BROKERAGE AUTHORIZATION FORM

Individual Name	
First: CLIENT FIRST NAME	Last: CLIENT LAST NAME
DDD ID: DDD ID	
Employer Name (this must be completed if different from Individual)	
First: EMPLOYER FIRST NAME	Last: EMPLOYER LAST NAME

This form is required if an individual/guardian has hired/will hire either an agency or a self-directed employee to provide DDD-approved Support Brokerage services. Completion and signing of this form grants the fiscal intermediary, Acumen Fiscal Agent, LLC, permission to talk with the Support Brokerage agency or self-directed employee identified below to discuss the individual's self-directed services, employees and/or community vendors, as applicable.

If the Support Brokerage provider is an agency, please list the name and contact information for the agency (*do not list agency administrator or individual staff*). If the Support Brokerage provider is a self-directed employee, please list the name and contact information for the employee.

Unless noted otherwise, this authorization is in effect from the Support Brokerage service prior authorization (PA) start date through the Support Brokerage service PA end date.

Support Broker Details			
First Name: SUPPORT BROKER	Last Name: SUPPORT BROKER	Phone: PHONE	
Email: SUPPORT BROKER EMAIL	Agency: SUPPORT BROKER AGENCY		

Agree and Sign: I confirm that the details given are accurate and complete.

Employer Signature: EMPLOYER SIGNATURE	Date: MM/DD/YYYY
Support Broker Signature: SUPPORT BROKER SIGNATURE	Date: MM/DD/YYYY

Acumen Fiscal Agent, LLC.
5416 E Baseline Rd., Suite 200
Mesa, AZ 85206
Toll-Free Phone: (833)-892-0413
Toll-Free Fax: (866)-486-4179
enrollment@acumen2.net
www.acumenfiscalagent.com

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Acumen Fiscal Agent
Innovation • Opportunity • Freedom

New Jersey Vendor Fiscal/Employer Agent Community Vendor Enrollment Form

Individual Name (please print): CLIENT NAME
Address: CLIENT ADDRESS
City: CLIENT CITY State: STATE Zip Code: ZIP CODE
Email: CLIENT EMAIL
Phone: CLIENT PHONE Cell Phone: CLIENT CELL DOB: MM/DD/YYYY
DDD ID Number: DDD ID Social Security Number: XXX-XX-XXXX

Authorized Representative Name: EMPLOYER NAME SS#: XXX-XX-XXXX
(SS# required for reimbursement)
Address: EMPLOYER ADDRESS
City: EMPLOYER CITY State: STATE Zip Code: ZIP CODE
Phone: EMPLOYER PHONE Email: EMPLOYER EMAIL
Authorized Representative Signature: EMPLOYER SIGNATURE Date: MM/DD/YYYY

Support Coordinator Name: SUPPORT COORDINATOR NAME

Phone: SC PHONE Email: SC EMAIL Fax #: SC FAX

****BLUE = REQUIRED FIELD**

****ORANGE – IF APPLICABLE**

☐ **SELECT ONE**



CHANGE INFORMATION FORM: PARTICIPANT/EMPLOYER

Please complete this form and return to Acumen by one of the following methods:

Mail: 5416 E Baseline Rd, Suite 200, Mesa, AZ 85206

Fax: (866) 486-4179

Email: enrollment@acumen2.net

Change PARTICIPANT Information			
Complete this section when there is a change in participant information. The participant is the individual receiving services. If the participant is also the employer, please complete this section only . 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 <input type="checkbox"/>	Address <input type="checkbox"/>	Phone Number <input type="checkbox"/> E-mail Address <input type="checkbox"/>
Current/Previous Name:	CLIENT NAME		
New Name (if changed):	NEW CLIENT NAME		
Street Address:	NEW CLIENT STREET ADDRESS		
City/State/Zip:	NEW CITY/STATE/ZIP CODE		
Phone Number:	NEW CLIENT PHONE NUMBER		
E-mail Address:	NEW CLIENT EMAIL		Client ID Number: CLIENT ID
Signature (Employer or Authorized Rep):	EMPLOYER SIGNATURE		
Date:	MM/DD/YYYY		
Change EMPLOYER Information			
Complete this section when there is a change in employer information. The employer is the individual who hires, trains, and manages staff. If the participant is also the employer, please complete the participant section only. 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 <input type="checkbox"/>	Address <input type="checkbox"/>	Phone Number <input type="checkbox"/> E-mail Address <input type="checkbox"/>
Current/Previous Name:	EMPLOYER NAME		
New Name (if changed):	NEW NAME		
Street Address (if changed):	NEW EMPLOYER ADDRESS		
City/State/Zip (if changed):	NEW CITY/STATE/ZIP		
Phone Number (if changed):	NEW PHONE NUMBER		
E-mail Address:	NEW EMPLOYER EMAIL		Client ID Number: CLIENT ID
Signature (Employer or Authorized Rep):	EMPLOYER SIGNATURE		
Date:	MM/DD/YYYY		

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