Public Partnerships LLC (PPL)
Indiana Family and Social Services Administration (FSSA)
Health & Wellness Waiver
Phone: 1-866-264-2296
Fax: 1-866-799-9381

Consumer and Employee Relationship Form

What is the purpose of this form?

Our contract with IN FSSA Health & Wellness has specific guidelines as to who is allowed to provide services to our consumers. Please complete this form with your employer.

I _____ provide services to the Participant or Consumer _____.
(Print Employee's Name) (Print Participant's Name)

My relationship to the consumer is: (Check one)

- ☐ I am his/her Spouse
- ☐ I am his/her Parent
- ☐ I am his/her Legal Guardian
- ☐ I am the Power of Attorney (POA); or Health Care Representative (HCR); or the person directing care for the consumer
- ☐ I am None of the Above

Note: If you are the spouse of the participant, you are not eligible to become the employee.

I hereby certify that the information presented above is correct to the best of my knowledge.

Employer Signature: _____

Employee Signature: _____

NEED HELP? CALL TOLL FREE 1-866-264-2296