

ATTENDANT DATA FORM

Attendant Information					
Name: _____					
First	Middle	Last			
Physical Address: _____					
Street	Apt/Unit #	City	State	Zip Code	
Mailing Address: _____					
<i>(if different than physical address)</i> Street/PO Box					
	Apt/Unit #	City	State	Zip Code	
Phone #: Home _____ Cell _____					
Email: _____					
Date of Birth: _____ Social Security Number: _____ - _____ - _____					
<input type="checkbox"/> Yes <input type="checkbox"/> No – The Consumer is my child <u>and</u> the Consumer is a minor under age 18?					
<input type="checkbox"/> Yes <input type="checkbox"/> No – The Consumer is my spouse?					
<i>If yes to either question above, the Attendant is ineligible to work under this program.</i>					
Employer Information					
Name of Employer of Record (EOR): _____					
EOR Phone #: _____					
EOR Email: _____					
Name of Consumer: _____					
Consumer Medicaid ID #: _____					
Age of Consumer (check one): <input type="checkbox"/> Adult 18 years old or older <input type="checkbox"/> Minor under age 18					
Note: If the Consumer is a minor, submit a Child Protective Services Central Registry Release of Information Form. Submit to Consumer Direct Care Network (CDCN).					

The EOR will receive an *Enrollment Confirmation Form* from CDCN. This confirms that CDCN has received and approved all employment paperwork. **CDCN is not the Attendant’s employer.**

The Attendant attests that the Attendant Information listed above is accurate. If this information changes, the Attendant must notify CDCN.

_____ <i>Attendant Signature</i>	_____ <i>Date</i>	_____ <i>Employer of Record Signature</i>	_____ <i>Date</i>
-------------------------------------	----------------------	--	----------------------

