



ATTENDANT DATA FORM

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.	Atte	endant Informatio	n		
Physical Address: Street	Name:				
Street Apt/Unit # City State Zip Code Mailing Address: (if different than physical address) Street/PO Box Apt/Unit # City State Zip Code Phone #: Home Cell				Last	
Mailing Address: (if different than physical address) Street/PO Box			0"	<u> </u>	
State Zip Code		• •	•	State	Zip Code
Phone #: Home Cell Email:				State	Zip Code
Email: Social Security Number: Yes No - The Consumer is my spouse? If yes to either question above, the Attendant is ineligible to work under this program. Employer Information	Phone #: Home	Cell	<u> </u>		
Date of Birth: Social Security Number:					
Yes No – The Consumer is my spouse? If yes to either question above, the Attendant is ineligible to work under this program. Employer Information					
Employer Information Name of Employer of Record (EOR): EOR Phone #: EOR Email: Name of Consumer: Consumer Medicaid ID #: Age of Consumer (check one): □ Adult 18 years old or older □ 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.	\square Yes \square No – The Consumer is my child <u>a</u>	nd the Consumer	is a minor unde	er age 18?	
Employer Information Name of Employer of Record (EOR): EOR Phone #: EOR Email: Name of Consumer: Consumer Medicaid ID #: Age of Consumer (check one):	\square Yes \square No – The Consumer is my spouse	e?			
Name of Employer of Record (EOR):	If yes to either question above, the Atte	ndant is ineligible	to work under t	his progra	m.
EOR Phone #: EOR Email: Name of Consumer: Consumer Medicaid ID #: Age of Consumer (check one):	Emp	oloyer Information	n		
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Attendant Sianature Date Employer of Record Sianature Date	Attendant Sianature Date		(5)		



