ATTENDANT DATA FORM

Attendant Information

Name: _____ _____ _____
First Middle Last

Physical Address: _____
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 _____

Email: _____

Date of Birth: _____ Social Security Number: _____ - _____ - _____

☐ Yes ☐ No – The Consumer is my child and the Consumer is a minor under age 18?

☐ Yes ☐ No – The Consumer is my spouse?

If yes to either question above, the Attendant is ineligible to work under this program.

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.

_____ _____ _____ _____
Attendant Signature *Date* *Employer of Record Signature* *Date*