CONSUMER DIRECT CARE NETWORK

OptimaHealth

CONSUMER DATA FORM

Reset/clear all fields > Clear Form

Consumer Information

Name in Program _____ _____ _____
First *Middle* *Last*

Consumer Physical Address _____
(Street address only. No PO Box. This is where service will be provided.)

City _____ **State** VA **Zip** _____ **County** _____

Phone _____ _____ **Email** _____
Home *Cell*

Medicaid ID _____ **Gender** ☐ Male ☐ Female

Date of Birth _____ **Social Security #** ___ - ___ - ____

Prior Fiscal Agent: ☐ Yes ☐ No – Is Consumer switching services to CDCN from another Fiscal Agent?

If yes, Agent Name: _____

Prior Employer of Record (EOR)?

☐ Yes ☐ No – Is Consumer switching their EOR? If yes, previous EOR name: _____

New Employer of Record (EOR) Information

EOR Relationship to Consumer ☐ Consumer (self) ☐ Other (describe): _____

Name on Social Security Card _____ _____ _____
First *Middle* *Last*

EOR Physical Address _____
(Street address only. No PO Box. This is where service will be provided.)

City _____ **State** _____ **Zip** _____ **County** _____

EOR Mailing Address *(Street or PO Box.)* _____

City _____ **State** _____ **Zip** _____

Phone _____ _____ _____
Home *Cell* *Fax*

Date of Birth _____ **Social Security #** ___ - ___ - ____ **Email** _____

Prior Accounts: ☐ Yes ☐ No – Does EOR have an existing Sole Proprietor or Household Employer business with established accounts? If yes, provide confirmation of your Employer Identification Number from the IRS (EIN Certification Letter 147C or EIN Confirmation Letter CP575).

Services Facilitator

Name _____

Phone _____ **Email** _____