CONSUMER DIRECT CARE NETWORK

VirginiaPremier™

# 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, the Attendant must complete a Dept of Social Services background check form.** The form will be sent to the Attendant in an email from Virginia DSS on behalf of Consumer Direct. The email will be from *CDVADSS@consumerdirectcare.*com. The subject line will be "*Virginia Central Registry Search Authorization"*. The Attendant needs to complete the form in one sitting. Click on the link in the email to begin filling out the DSS background check form.

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*