CONSUMER DIRECT CARE NETWORK

Sentara Health Plans

CONSUMER DATA 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** ________ **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*

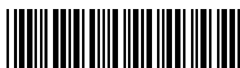
Date of Birth ____________ **Social Security #** _____ - ____ - ______ **Email** ____________________

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** ____________________

Rev. 12/11/2023 

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