

**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 \_\_\_\_\_

