

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 _____

