CONSUMER DIRECT CARE NETWORK

TENNESSEE | CHOICES Program

# MEMBER DATA FORM

Reset/clear all fields > Clear Form

## Member Information

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

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

**City** _____ **State** TN **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: _____

## Employer of Record (EOR) Information

**EOR Relationship to Member** ☐ Member (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** _____

**Email Correspondence:** ☐ Yes ☐ No – I wish to receive documents and information via email when available.

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

**Employer of Record Signature:** _____ **Date:** _____