CONSUMER DIRECT CARE NETWORK

SELF-DETERMINATION WAIVER PROGRAM (SDWP)

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 Member 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:** _____