Clear Form

CONSUMER DIRECT CARE NETWORK

EMPLOYMENT AND COMMUNITY FIRST CHOICES PROGRAM

WORKER DATA FORM

Worker Information

Name: _____ _____ _____
First Middle Last

Maiden or Previous Last Name: _____

Physical Address: _____
Street Apt/Unit # City State Zip Code

County: _____

Mailing Address: _____
(if different than physical address) Street/PO Box Apt/Unit # City State Zip Code

Phone #: Home _____ Cell _____ Email: _____

We may reach out to you via SMS/Text Messaging concerning your services with CDCN. Please note that CDCN will never request sensitive personal information, such as your Social Security Number, banking details, address, or date of birth through text messages. If you receive an SMS message from CDCN and would like to opt-out from future SMS messages, please respond to the initial message with "STOP"

Date of Birth: ___/___/_____ Social Security Number: _____ - _____ - _____

I must be 18 years of age or older to provide care.

Gender: ☐ Male ☐ Female ☐ Prefer not to disclose

Your relationship to Member: _____

Emergency Contact Name: _____ Phone Number: _____

☐ Yes ☐ No I am the Member's Spouse, Legal Guardian, Representative, or Power of Attorney, or live with the Member.

If yes, you cannot provide service to the Member per program rules.

☐ Yes ☐ No I am the Member's Conservator.

If yes, you must have a court order saying that it's okay to be paid to provide care to the Member.

Employer Information

Name of Employer of Record (EOR): _____

EOR Phone #: _____

EOR Email: _____

Name of Member: _____

Member CDTN ID #: _____

I understand and accept:

- I hereby authorize and consent to release the information provided on this Data Form and other application materials to CDTN for the purpose of running background checks. I understand results will be made available to my prospective employer and TennCare[SM], as necessary. I cannot be hired until I pass my background check.
- CDTN can contact me using the contact information on my Data Form.
- I will receive an Okay to Work letter from CDTN if I am eligible to provide care under this program. I cannot begin working until I receive my Okay to Work date. **CDTN is not my employer.**

I attest that the information listed above is accurate. If this information changes, I will notify CDTN.

Worker Signature _____ Date _____