

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

Yes No I am the Member's Spouse, Legal Guardian, Representative, or Power of Attorney.
If yes, you cannot provide service to the Member per program rules.

Yes No I am the Member's Parent **and** the Member is under the age of 18.
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.

Your relationship to Member _____

Emergency Contact Name: _____ Phone Number: _____



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 TennCareSM, 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