CONSUMER DIRECT CARE NETWORK

Clear Form

FISCAL AGENT REQUEST FORM (FARF)

Please email completed form to CDCN at **VAReferrals@ConsumerDirectCare.com** or fax it to 1-877-571-8649.

Services Facilitator/Agency Information	
Agency Name:	Agency NPI #:
Services Facilitator Name:	Services Facilitator Phone #:
Services Facilitator Email:	

Referral Date		**Effective Date**		**Agency Authorizing Services**	--select--

Referral Type/Service Request

☐ **Yes** ☐ **No** – Is the individual new to consumer directed services?

☐ Existing Consumer transitioning to CDCN from a different Fiscal Employer Agent

Prior FEA: _____

☐ Existing Consumer changing their Employer of Record

Prior EOR: _____ New EOR: _____

New EOR submits (1) a New EOR packet and (2) an EOR Change Attendant Attestation Form for each Attendant.

☐ Existing Consumer-Loss of Eligibility

Prior Enrollment (Fee-For-Service/MCO): --select--

New Enrollment (Fee-For-Service/MCO): --select--

☐ Existing Consumer changing their Services Facilitator

Consumer Information		
First Name:	Last Name:	Medicaid I.D. #:
Date of Birth:	Social Security Number:	Telephone:
Email Address:		
Physical Address (Street/City/State/Zip):		

Employer of Record Information		
☐ Yes ☐ No – Consumer will be the Employer of Record? **If NO, complete below. If YES, Stop.**		
First Name:	Last Name:	Telephone:
Email Address:		

Enrollment/Transition Packet Submittal

The Employer of Record is encouraged to complete and submit an electronic Enrollment or Transition Packet to CDCN via DocuSign. DocuSign packets can be accessed on the CDCN website at **www.consumerdirectva.com/forms/**.

Hard copies of blank packets are available upon request. Filling out the packet electronically results in faster processing and fewer errors. If Consumer/EOR requests a paper packet, please complete below.

☐ Please mail a paper Employer Enrollment/Transition Packet to:

Name: _____

Mailing Address: _____

Street *City* *State* *Zip*