CONSULTANT REGISTRATION
AGENCY - AFFILIATED

Consultant Name: _____ _____
First Name Last Name

Medicaid Treating Provider Number: _____

Agency Affiliation: _____
Agency's Complete Name

Agency's Medicaid Group Number: _____

Mailing Address: _____

This is my --
home address ☐
agency address ☐

_____
_____ _____ _____
City State Zip Code

Counties Served: _____

_____

Phone Number: Home _____ Work _____

Fax Number: Home _____ Work _____

E-Mail Address: _____

Date Trained: _____
mm/day(s)/yy

OFFICE USE ONLY	INITIAL	DATE
Received by District		
Sent to Central Office		
Received by Cent. Office		
Sent to DOEA		
Received by DOEA		
Entered into DOEA Db		

I am requesting a Medicaid Treating Provider Number for Consumer Directed Care Plus with a *specialty code 68*.

Signature: _____ Date: _____

Print Name: _____

Instructions: *This form should be completed by each consultant only once – during training – unless requested by the department to complete it again.* Complete the entire form. **Please print legibly!**

The "Medicaid Treating Provider Number" is a 9-digit number which is assigned to you individually. **Write in only the first 7 digits** (i.e., omit the last two, which for WSCs is "96"). If you have applied for, but have not yet received, a Medicaid Treating Provider Number, leave blank or write "Pending" on this line. The Agency's Medicaid Group Number is also a 9-digit number. Again, enter only the first 7 digits. If you do not know what it is, do not complete this line.

It is extremely important that your name, your agency's name and the mailing address be written consistently on all project materials. The mailing address should be the address to which you want all project materials sent (randomization letter, budgets, etc.). **Check appropriate box.** Complete and sign a Memorandum of Agreement only if you are authorized to bind your agency contractually. Otherwise, be sure an appropriate person in your agency has signed an MOA. Please give the completed form (and MOA, if applicable) to the CDC+ contact in the District Developmental Disabilities Program. The district keeps the originals and sends a copy of this form to Central Developmental Disabilities Program Office. Thank you