

## Consumer Directed Care Plus (CDC+) Consultant and Agency Registration Update Form

**Instructions:** Please type or clearly print all information. The **top part** of this form is to be completed by a Consultant to update his or her personal information. The **bottom part** of this form is to be completed by an Agency Representative to update agency information. Please do **NOT** update information for a consultant and a group agency on the same form. ❶ Type or print the name of the consultant and the associated Medicaid Provider Number for CDC+. ❷ Then complete both Current Registration Information and Update To information *only for the item(s) to be changed*. ❸ Type or print the name of the agency and the agency's Medicaid Group Provider Number for CDC+. Then complete the Current Registration Information and Updated Information data for items that have changed. ❹ Sign and date the form. Agency changes (\*) must be signed by authorized personnel only. Keep a copy for your records and give original form to district. District keeps original and sends a copy to Central Office for processing. **NOTE:** A new MOA and a new "Consultant Registration ~Solo Practitioner" form must accompany this form when consultant changes from agency-affiliated to **solo practitioner**. An MOA, Agency Registration, and "Consultant Registration ~Agency Affiliated" form must accompany this form when consultant forms a **new hiring (i.e., group) agency**. A new "Consultant Registration ~ Agency Affiliated" form must accompany this form when consultant leaves one hiring agency or solo practice and becomes employed by another hiring agency.

	Current Registration Information:	Updated Information:
❶ Consultant Name		
❶ Consultant Medicaid Provider #	_ _ _ _ _ 6 8	
❷ Provide <b>name</b> of company with which you are affiliated. [If solo practitioner, put your name or your independent business name; if with an agency, put agency name.]	<u>Agency/Solo Practitioner (MUST Circle one)</u>	<u>Agency/Solo Practitioner (MUST Circle one)</u>
❷ Provide <b>address</b> to which all your CDC+ materials (randomizations, budget forms, project notices, etc.) are to be mailed.		
❷ Home Phone/Fax Number	( ) / ( )	( ) / ( )
❷ Business Phone/Fax Number	( ) / ( )	( ) / ( )
❷ E-mail Address		
❷ Counties Served		
❷* Agency Name		
❷* Agency Medicaid Group Provider #	_ _ _ _ _ 6 8	
❷* Agency Mailing Address		
❷* Phone Number	( )	( )
❷* Fax Number	( )	( )
❷* Counties Served		

❶ Signature \_\_\_\_\_ ❷ Date \_\_\_\_\_  
I certify that if any changes are made to items marked by "\*" on this form, I am that agency's authorized representative.

❶ Print Name \_\_\_\_\_

01/01/04

OFFICE USE	INI'L	DATE
Received by District		
Sent to Central Office		
Received by Cent. Ofc.		
Sent to DOEA		
Received by DOEA		
Entered into DOEA Db		