CONSUMER DIRECT CARE NETWORK

AUTHORIZED REPRESENTATIVE DATA & BACKGROUND CHECK CONSENT FORM

Instructions for Applicants: Supply the information below to set up your authorized representative file and conduct a background check as required by program rules. Review and sign the consent.

Authorized Representative Contact/Background Check Information

Name: _____ _____ _____
First Middle Last

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

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

County: _____

Phone #: Home (____) _____ Cell (____) _____

Email: _____

Emergency Contact: _____ _____ _____
Name Phone Relationship

Gender: ☐ Male ☐ Female ☐ Prefer not to disclose

Date of Birth: _____ Social Security#: _____-_____ - _____

Authorized Representative Relationships

Name of Veteran Receiving Services: _____

Authorized Representative's family relationship, if any, to Veteran Receiving Services: _____

Name of Employer of Record: _____
(Veteran or Veteran's Representative)

Authorization to Obtain and Consent to Release Background Check Information – I understand the information request above is to set me up in the Consumer Direct Care Network's (CDCN) accounting system and to obtain a criminal background check on me through the Colorado Bureau of Investigation. I authorize release of the background check findings to the Veteran Directed Care (VDC) program authorizing agency, the Denver Regional Council of Governments, **the VA Eastern Colorado Health System, the VDC Employer of Record and/or the VDC Participant** who will determine if there are any disqualifying offenses that would prevent me from working for the program participant. I understand this will not be used to discriminate against me in violation of any law.

Signature of Applicant: _____ Date: _____

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