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: _____