CENTER FOR INDEPENDENCE – COLORADO
VETERAN CHOICE PROGRAM
DIRECT CARE PROFESSIONAL SET-UP FORM

Instructions: Please fill out any information in Sections 1 and 2, where applicable. Both the Direct Care Professional and the Veteran, or the Veteran's Authorized Representative, must sign and date the bottom to be considered complete. Please submit the completed form to PremierFMS via one of the following options:

Mail	Email	Fax
10425 W North Ave Suite 345 Milwaukee, WI 53226	CFI@premier-fms.com	855.334.3866

DIRECT CARE PROFESSIONAL'S INFORMATION

First Name: ________________ Middle Initial: _____ Last Name: ________________

Mailing Address: ________________ City: ____________ State: ______ Zip: ________

Home #: ______________ Mobile #: ______________ Work #: ______________

Email Address: ____

Date of Birth: ______ / ______ / ______ Social Security Number: ______ - ______ - ________

VETERAN'S INFORMATION

First Name: ________________ Middle Initial: _____ Last Name: ________________

Mailing Address: ________________ City: ____________ State: ______ Zip: ________

Home #: ______________ Mobile #: ______________ Work #: ______________

Email Address: ____________________________ Date of Birth: ______ / ______ / ______

EMPLOYER INFORMATION

First Name: ________________ Middle Initial: _____ Last Name: ________________

By signing below, you certify that the information on this form is accurate and that you have all supporting documentation that may be needed to verify your selection. For any questions or concerns, please contact our office at (855) 287-6638.

Direct Care Professional Signature: ______________________ Date: ______ / ______ / ______

Employer Signature: ______________________________ Date: ______ / ______ / ______