AD*vantage* Program
Consumer-Directed Personal Services and Supports (CD-PASS)

Acknowledgment of CD-PASS Employer Training

Member Information

_____ _____ / _____ / _____
SoonerCare ID Number Date of Birth

_____ _____ _____
Last Name First Name M.I.

_____
Address

_____ _____ _____ (____) - _____
City State Zip Phone

Acknowledgment of Responsibilities for CD-PASS Services
Please check the ☐ **Yes** or ☐ **No** box indicating your completion and agreement of the following:

1.	I have received and completed the Self Guided Employer Training and understand my role and responsibility as an employer in CD-PASS. ____/ ____ / _____ _____ Date Completed Member Signature ____/ ____ / _____ _____ Date Completed Authorized Representative Signature*	☐ Yes ☐ No
2.	I chose to complete the Employer Training facilitated by the FMS in my home and understand my role and responsibility as an employer in CD-PASS. ____/ ____ / _____ _____ Date Completed Member Signature ____/ ____ / _____ _____ Date Completed Authorized Representative Signature*	☐ Yes ☐ No

*You will only have an Authorized Representative if you've appointed one. If you do not have one, leave this line blank.