OMB Control Number 0985-0040 Expiration Month/Day/2023

	TEAM MEMBER FORM						
* Items market	d with asterisk (*) indica	ate required fields					
Team Memb	oer Name						
First Name *:		Middle In	itial: Last	Name *:			
Nickname:							
Team Memb	oer Contact Informa	ntion					
Primary Phone	Number *:		Address:				
		_	City:				
Drimary Dhana	Number Extension						
Filliary Filone	Number Extension:		Zip Code *: _				
Secondary Phor	ne Number :		State/Territory	/ * :			
Casandany Dhan	aa Numbar Eutonaian		County *:				
Secondary Phor	ne Number Extension:						
Email Address:							
Team Memb	oer Details						
			Partner Organ				
			(Indicate prim	ary org. that to	eam member is affiliated with):		
Start Date * :							
			_				
End Date (if app	plicable):						
			_				
Status * (Select	only one):		Paid Status *	(Select only or	ne):		
□ Active	□ Inactive	□ Retired	□ In-Kind-	□ MIPP	□ SHIP-Paid □ Volunteer		
			Paid	A-Paid			
	oer Demographic In	formation					
_	le selections allowed):						
	lian or Alaskan Native		□ Native Hawaiia	an or Other Pa	icific Islander		
□Asian □Black or Afric	oon American		□ White □ Other				
□Hispanic or L			□ Not Collected				
Thispanic of L	atino		- Not Confected				
Date of Birth *	:						
Gender * (Selec	ct only one): Female	e □ Male		Other	■ Not Collected		

Team Member Demographic Information (continued)							
Primary Language *(Select only one):		Sec	condary Language: (Select	only	one):		
□ English			English				
□ Chinese			Chinese				
□ Korean			Korean				
□ Russian			Russian				
□ Spanish			Spanish				
□ Vietnamese			American Sign Language				
☐ American Sign Language			Vietnamese				
□ Other			Other				
Team Member STARS Details		-					
Role * (Select only one):							
□ SHIP Assistant Director	□ Sit	□ Site Manager			Team Member		
□ State Staff	□ Sub-State		Staff		STARS Submitter		
□ Sub-State Manager	□ Sit	te Staff					
Send Login Credentials:		es	□No				
Revoke Login:		es	□No				
Program * (Multiple selections allowed):		HIP	□SMP (Enter SIRS eFile	ID,	if applicable):		
		IPPA					
Team Member Unique ID Details							
Create 1-800 Medicare Unique ID Number *:		es	□No				
Send 1-800 Medicare Unique ID Number:		es	□No				
Status of 1-800-Medicare Unique ID Number *:		ctive	□ Inactive				
Notes							

OMB Control Number 0985-0	J040 Expiration Mon	th/Day/2023	

Public Burden Statement:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless such collection displays a valid OMB control number (OMB 0985-0040). Public reporting burden for this collection of information averages 5 minutes per response, including time for gathering, maintaining, completing and reviewing the collection of information. The obligation to respond to this collection is required to retain or maintain benefits under the statutory authority from Section 4360(f) of the OBRA.