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

TEAM MEMBER FORM

*** Items marked with asterisk (*) indicate required fields**

Team Member Name

First Name *: _____ Middle Initial: _____ Last Name *:

_____

Nickname: _____

Team Member Contact Information

Primary Phone Number *:

_____

Primary Phone Number Extension: _____

Secondary Phone Number :

_____

Secondary Phone Number Extension: _____

Email Address:_____

Address: _____

City: _____

Zip Code *: _____

State/Territory *: _____

County *:

_____

Team Member Details

Start Date * : _____

End Date (if applicable): _____

Partner Organization Affiliation *
(Indicate primary org. that team member is affiliated with):

_____

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_____

_

Status * (Select only one):

❑ Active ❑ Inactive ❑ Retired

Paid Status * (Select only one):

❑ In-Kind-Paid ❑ MIPP A-Paid ❑ SHIP-Paid ❑ Volunteer

Team Member Demographic Information

Race * (Multiple selections allowed):

❑ American Indian or Alaskan Native
❑ Asian
❑ Black or African American
❑ Hispanic or Latino
❑ Native Hawaiian or Other Pacific Islander
❑ White
❑ Other
❑ Not Collected

Date of Birth *:_____

Gender * (Select only one): ❑ Female ❑ Male ❑ Other ❑ Not Collected

Team Member Demographic Information (continued)

Primary Language *(Select only one):

- ❑ English
- ❑ Chinese
- ❑ Korean
- ❑ Russian
- ❑ Spanish
- ❑ Vietnamese
- ❑ American Sign Language
- ❑ Other

Secondary Language: (Select only one):

- ❑ English
- ❑ Chinese
- ❑ Korean
- ❑ Russian
- ❑ Spanish
- ❑ American Sign Language
- ❑ Vietnamese
- ❑ Other

Team Member STARS Details

Role * (Select only one):

- ❑ SHIP Assistant Director
- ❑ State Staff
- ❑ Sub-State Manager
- ❑ Site Manager
- ❑ Sub-State Staff
- ❑ Site Staff
- ❑ Team Member
- ❑ STARS Submitter

Send Login Credentials: ❑ Yes ❑ No

Revoke Login: ❑ Yes ❑ No

Program * (Multiple selections allowed): ❑ SHIP ❑ SMP (Enter SIRS eFile ID, if applicable): _____ ❑ MIPPA

Team Member Unique ID Details

Create 1-800 Medicare Unique ID Number *: ❑ Yes ❑ No

Send 1-800 Medicare Unique ID Number: ❑ Yes ❑ No

Status of 1-800-Medicare Unique ID Number * : ❑ Active ❑ Inactive

Notes

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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.