



APPALACHIAN CENTER FOR INDEPENDENT LIVING STATUS CHANGE

Name: _____ Effective Date: _____

Last 4 Digits of SSN: _____
(Direct Care Worker only)

Veteran's Name: _____
(Not required for Vendor)

INSTRUCTIONS: Complete the section above, fill out *only* the applicable sections below. Sign and date the form and submit to ResilientSD:

Mail

10425 W. North Ave
Suite 345
Milwaukee, WI 53226

Email

APPCIL@Resilient-SD.com

For any questions or concerns, please contact our office at: **833.855.3941**.

SECTION 1: NAME CHANGE

New Name: _____ Address: _____

Vendors, please submit a new W-9 when requesting a change

SECTION 2: ADDRESS CHANGE

New

Add

SECTION 3: PHONE CHANGE

Phone #: _____ New Email: _____

New

Add

New

Add

SECTION 4: EMAIL CHANGE

SECTION 5: EMPLOYMENT CHANGE

Last Day Worked: _____ Termination Reason: _____
(Optional)

Re-Hire Date: _____

Direct Care Worker Signature: _____ Date: _____

Veteran/Authorized Representative Signature: _____ Date: _____