



# CENTER FOR INDEPENDENCE VETERAN CHOICE PROGRAM RATE AGREEMENT

**INSTRUCTIONS:** Please fill out each section as appropriate. Both the Direct Care Worker and the Veteran, or the Veteran’s Authorized Representative, must sign and date the bottom to be considered complete. Please submit completed form to ResilientSD:

**Mail**  
10425 W. North Ave  
Suite 345  
Milwaukee, WI 53226

**Email**  
[Enrollment@Resilient-SD.com](mailto:Enrollment@Resilient-SD.com)

## SECTION 1: DIRECT CARE WORKER INFORMATION

Name: \_\_\_\_\_ Last 4 Digits of SSN: \_\_\_\_\_

Veteran’s Full Name: \_\_\_\_\_

Employer of Record Name: \_\_\_\_\_

## SECTION 2: RATE AGREEMENT INFORMATION

| Service Type                            | Wage | Per  | Effective Date |
|---|------|------|----------------|
| Personal Assistance Services & Supports |      | Hour |                |

For any questions or concerns, please contact our office at: **855.613.2898**.

Direct Care Worker Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Veteran/Authorized Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_