MOUNTAIN STATE CENTERS FOR INDEPENDENT LIVING/FIL 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

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: **888.490.8470**.

Direct Care Worker Signature: ______________________________ Date: __________

Veteran/Authorized Representative Signature: ______________________________ Date: __________