



# MOUNTAIN STATE CENTERS FOR INDEPENDENT LIVING/FIL BACKGROUND CHECK DISCLOSURE

As part of the Veteran Directed Program, ResilientSD is required to conduct applicable background checks before the Authorized Representative is eligible to begin serving as the Authorized Representative/Employer for a Veteran. Successfully passing the background checks is a condition of representing the Veteran.

**INSTRUCTIONS:** Please fill out all the information in Section 1 and Section 2. The Authorized Representative must sign and date 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: VETERAN INFORMATION

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

## SECTION 2: AUTHORIZED REPRESENTATIVE INFORMATION

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Physical Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home #: \_\_\_\_\_ Mobile #: \_\_\_\_\_ Work #: \_\_\_\_\_

Email Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

For any questions or concerns, please contact our office at: **888.480.8470**.

## AUTHORIZATION

By signing below, I certify that the information provided above is accurate. I authorize ResilientSD to conduct a background check now and to conduct future background checks – without notice – based on contractual requirements for as long as I serve as an Authorized Representative. Furthermore, I understand that the results of the background checks will be shared with the Veteran Directed Care Program Operations Manager and the Veteran.

Authorized Representative Signature: \_\_\_\_\_ Date: \_\_\_\_\_