ResilientSD
Part of the AssuranceSD Family

APPALACHIAN CENTER FOR INDEPENDENT LIVING STATUS CHANGE

CHANGE REQUEST FOR:

☐ Veteran ☐ Employer ☐ Direct Care Worker ☐ Vendor

Name (Change for): _____ Effective Date: _____

Veteran Receiving Services: _____

ADDRESS CHANGE

Address Type: ☐ Mailing ☐ Physical

Change To: _____

EMAIL CHANGE

Change To: _____

PHONE NUMBER

Change Type: ☐ New ☐ Add

Type: ☐ Home ☐ Cell ☐ Business

New Phone Number: _____

NAME CHANGE

Previous Name: _____ New Name: _____

Veterans: Please submit a copy of your updated Social Security Card
Direct Care Workers: Please submit a copy of your updated Social Security Card and updated W-4
Vendors: Please submit a new W-9 when requesting a name change

STATUS CHANGE (*Note: We will process timesheets up to the date and time below.)*

Veteran: ☐ Disenrollment ☐ Budget Suspension ☐ Budget Suspension Release

Date: _____ Time: _____ Reason: _____

Direct Care Worker: ☐ Termination ☐ Rehire

Effective Date: _____ Last Day Worked: _____ Reason: _____

Submit completed form to: APPCIL@Resilient-SD.com. If a name change is required, please include supporting documentation.

Print Name	Signature	Date

*Name of the person the changes are for, or VDC Care Team