

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: SLCO@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