



# OREGON VETERAN DIRECTED CARE STATUS CHANGE FORM

Name: \_\_\_\_\_ Effective Date: \_\_\_ / \_\_\_ / \_\_\_

Last 4 Digits of SSN: \_\_\_\_\_  
(Worker only)

Veteran's Name: \_\_\_\_\_  
(Not required for vendor)

**Instructions:** After completing the section above in full, complete *ONLY* the updated sections below then sign and date. Please submit the completed form to **Premier Financial Management Services (PFMS)** via one of the following options:

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

**Email:**  
ORVSDP@premier-fms.com

**Fax:**  
1-855-571-7670

### SECTION 1

### SECTION 2

New Name: \_\_\_\_\_ Address: \_\_\_\_\_

Please submit an updated ID when requesting a name change.  
Vendors, please submit a new W-9 when requesting a name change.

New  Add

### SECTION 3

### SECTION 4

Phone Number: \_\_\_\_\_ New Email: \_\_\_\_\_

New  Add  New  Add

### SECTION 5

Last day worked: \_\_\_ / \_\_\_ / \_\_\_\_\_ Termination Reason: \_\_\_\_\_  
(Optional)

Re-hire Date: \_\_\_ / \_\_\_ / \_\_\_\_\_

Care Provider Signature: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_\_\_

Veteran/Employer Signature: \_\_\_\_\_ Date: \_\_\_ / \_\_\_ / \_\_\_\_\_