



**Premier**  
FINANCIAL MANAGEMENT SERVICES  
Part of the AssuranceSD family

OREGON VETERAN DIRECTED CARE  
Status & Information Change Form

**Veteran Name:** \_\_\_\_\_

**Demographic Changes**

Change for: \_\_\_\_\_

Name: \_\_\_\_\_

Effective Date: \_\_\_\_\_

Type of Change: \_\_\_\_\_

Change To: \_\_\_\_\_

**Name Change**

Change for: \_\_\_\_\_

Effective Date: \_\_\_\_\_

Previous Name: \_\_\_\_\_ New Name: \_\_\_\_\_

***Worker**, we will need a copy of you updated Social Security Card, and updated W4.*

***Participant**, we will need a copy of your updated Social Security Card*

***Vendors**, please submit a new W-9 when requesting a name change.*

**Status Change**

Change for: \_\_\_\_\_

Name: \_\_\_\_\_

Effective Date: \_\_\_\_\_

Type: \_\_\_\_\_ Reason: \_\_\_\_\_

**Spending Plan Change**

Effective Date: \_\_\_\_\_

Type: \_\_\_\_\_

Change Notes: \_\_\_\_\_

Type: \_\_\_\_\_

Change Notes: \_\_\_\_\_

Type: \_\_\_\_\_

Change Notes: \_\_\_\_\_

**Include supporting documents and submit form to:** [orvsdp@premier-fms.com](mailto:orvsdp@premier-fms.com)

COMMENTS: \_\_\_\_\_

Worker Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

Care Manager Signature: \_\_\_\_\_ Date: \_\_\_\_\_