CHANGE INFORMATION FORM: PARTICIPANT or EMPLOYER

Complete this top section when there is a change in the **PARTICIPANT**'s (the individual receiving care services) information. If the Participant is also the Employer, please complete this top section **ONLY**.

FOR A NAME CHANGE: please provide your registered & new names and complete & return this form along with a copy of your Social Security card showing your new name.

Change In (select all that apply): **Name☐** **Address ☐** **Phone Number ☐** **E-mail Address ☐**	
PARTICIPANT Name:	New Name (if changed):
Physical Address (if changed):	
Mailing Address (if changed):	
Phone Number:	
E-mail Address:	
Acumen Participant ID Number and program (CDO, VDC, CLP-PD):	
Signature (Employer or Authorized Rep):	
Date: Participant is also the Employer	

Complete the bottom section when there is a change in the **EMPLOYER**'s (the person managing the care services & budget) contact information. If the Participant is also the Employer, please complete the top section **ONLY**.

FOR A NAME CHANGE: please provide your registered & new names and complete & return this form along with a copy of your Social Security card showing your new name.

Change In (select all that apply): **Name☐** **Address ☐** **Phone Number ☐** **E-mail Address ☐**	
EMPLOYER Name:	New Name (if changed):
Physical Address (if changed):	
Mailing Address (if changed):	
Phone Number (if changed):	
E-mail Address:	
Acumen Participant ID Number and program (CDO, VDC, CLP-PD):	
Signature (Employer or Authorized Rep):	
Date:	

Please return this completed form & any additional forms to Acumen by:

Fax: (808) 427-8180 / Email: enrollment-hi@acumen2.net
Mail: 1003 Bishop Street, Ste. 1100, Pauahi Tower, Honolulu, HI 96813