



## Self-Directed Services Employee Change Form

931 Spa Road | Annapolis, MD 21401

Submittal: [FMSEmployeeUpdates@thearcccr.org](mailto:FMSEmployeeUpdates@thearcccr.org)

FMS Phone: 1.866.252.6871 | FMS Fax: 1.888.272.2236

**Please identify the employee and employer requesting the update.**

EMPLOYEE NAME:	
EMPLOYER NAME:	DEPT #:

**Please complete only the sections that apply.**

CHECK (✓) ALL THAT APPLY	CHANGE TYPE	DATA/DOCUMENTATION REQUIRED FOR CHANGE	EFFECTIVE DATE (Required)
	NAME	Previous Legal Name: _____ New Legal Name: _____ NOTE: Please provide a copy of your Social Security Card for confirmation. A marriage license CANNOT be accepted for confirmation purposes.	
	CONTACT INFO	Address: _____ Phone: _____ Email: _____ <input type="checkbox"/> RESIDENCE <input type="checkbox"/> MAILING <input type="checkbox"/> BOTH	
	SERVICE CODE	Service Code: _____ <input type="checkbox"/> ADD <input type="checkbox"/> REMOVE Service Code: _____ <input type="checkbox"/> ADD <input type="checkbox"/> REMOVE Service Code: _____ <input type="checkbox"/> ADD <input type="checkbox"/> REMOVE	
	PAY RATE	Current Hourly Rate: _____ New Hourly Rate: _____ <input type="checkbox"/> APPLY TO ALL SERVICE CODES <input type="checkbox"/> APPLY ONLY TO THE FOLLOWING SERVICE CODE(S):	
	OTHER	Please specify:	

**By signing below, I have been notified of and agree to the changes being submitted.**

EMPLOYEE SIGNATURE:	DATE:
EMPLOYER / DESIGNATED REPRESENTATIVE SIGNATURE:	DATE: