Form Approved
OMB NO. 0960-0644

EIN: ____________
SSA#: ___________

# Employment Network Contract Change Form

Please use this form if you wish to request changes to your Employment Network contract. Simply fill in the applicable information below and submit to MAXIMUS by fax to 703-683-3289. All fields within each selected section below must be filled out.

- For changes to your corporate status (official name or EIN), please use section Q.
- For changes to banking information, please see section R.

****Please Note: if this form is submitted via email, it must be sent by the named Signatory Authority, Primary Contact, or Authorized Negotiator identified in your EN RFP/contract. If this form is faxed, it must be signed by the same.**

If you have any questions, please contact the MAXIMUS Ticket to Work office, TicketServices@YourTickettoWork.com, or toll-free at 866-968-7842 (1-866-YourTicket).

Please select the section(s) to which you wish to make changes by putting an "X" on the line. Where appropriate, select whether you wish to add or delete information.

**A. ___ Add, Delete, or Change Doing Business As (DBA) Name**
Name: ________________________________ **Add [ ] Change [ ] Delete [ ]**

**B. ___ Use Text Field**
Display the following text below your EN name in the EN Directory (270 character maximum):
______________________________________________________________________
______________________________________________________________________

**C. ___ Change Mailing Address to** ______________________________________________
______________________________________________
______________________________________________

**D. ___ Change Actual Address to** ______________________________________________
______________________________________________
______________________________________________

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**E. ___ Change Beneficiary Contact Information to** (beneficiary's will be given this information in order to contact your EN.):

Contact Name: ________________________________
Phone: (____)______-___________ Toll Free #: (____)_____-_________
Fax: (____)_____ -____________ TTY: (____)____ -_____________
Email: ________________________________________

- ❑ Former contact no longer with the organization

**F. ___ Change Primary Contact Information to**

Contact Name: ________________________________
Phone: (____)______-___________ Toll Free #: (____)_____-_________
Fax: (____)_____ -____________ TTY: (____)____ -_____________
Email: ________________________________________

- ❑ Former contact no longer with the organization

**G. ___ Change Signatory Authority Contact Information to**

Contact Name: ________________________________
Phone: (____)______-___________ Toll Free #: (____)_____-_________
Fax: (____)_____ -____________ TTY: (____)____ -_____________
Email: ________________________________________

- ❑ Former contact no longer with the organization

**H. ___ Add or Delete Authorized Negotiators**

Name: _______________________________________ **Add [ ] Delete [ ]**

Name: _______________________________________ **Add [ ] Delete [ ]**

Name: _______________________________________ **Add [ ] Delete [ ]**

**I. ___ Change Payment Contact Information to**
*(EN-designated contact to receive notices and statements and follow-up inquiries from the Social Security Administration and the MAXIMUS EN Payment Department)*

Contact Name: ________________________________
Phone: (____)______-___________ Toll Free #: (____)_____-_________
Fax: (____)_____ -____________ TTY: (____)____ -_____________
Email: ________________________________________

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**J. ___ Change Payment Status Report Information to**
*(EN-designated contact to receive EN Payment Status Report from the MAXIMUS EN Payment Department. May be different than the EN Payment Information Contact above)*

Contact Name: ________________________________
Phone: (____)______-___________ Toll Free #: (____)_____-_________
Fax: (____)_____ -_____________ TTY: (____)____ -_____________
Email: ________________________________________

**K. ___ Add, Delete, or Change Website**
Website Address ____________________________________ **Add [ ] Delete [ ]**

Do you want a link to this website on the Employment Network Directory? **Yes [ ] No [ ]**

**L. ___ Change Type of Organization to: (check all that apply)**

___ Advocacy Group
___ Business/Employer
___ Community Based Organization
___ Education/Training
___ Faith-based Organization
___ Healthcare Provider
___ State/Local Government
___ Transportation/Transit

**M. ___ Add or Delete Preferred Impairment Groups Served:**

Impairment Group: _______________________________________ **Add [ ] Delete [ ]**
Impairment Group: _______________________________________ **Add [ ] Delete [ ]**
Impairment Group: _______________________________________ **Add [ ] Delete [ ]**
Impairment Group: _______________________________________ **Add [ ] Delete [ ]**
Impairment Group: _______________________________________ **Add [ ] Delete [ ]**
Impairment Group: _______________________________________ **Add [ ] Delete [ ]**
Impairment Group: _______________________________________ **Add [ ] Delete [ ]**
Impairment Group: _______________________________________ **Add [ ] Delete [ ]**
Impairment Group: _______________________________________ **Add [ ] Delete [ ]**

**N. ___ Add or Delete Services Offered**

Service: _______________________________________ **Add [ ] Delete [ ]**
Service: _______________________________________ **Add [ ] Delete [ ]**
Service: _______________________________________ **Add [ ] Delete [ ]**
Service: _______________________________________ **Add [ ] Delete [ ]**
Service: _______________________________________ **Add [ ] Delete [ ]**
Service: _______________________________________ **Add [ ] Delete [ ]**

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Service: ________________________________________ **Add [ ]** **Delete [ ]**
Service: ________________________________________ **Add [ ]** **Delete [ ]**
Service: ________________________________________ **Add [ ]** **Delete [ ]**

**O. ___ Add or Delete Service Areas to**

___ **National** (serving all states and US Territories) **Add [ ]** **Delete [ ]**
___ **Multi-State** (list all states you wish to change - you may use the two letter state abbreviation)

State: _______ **Add [ ]** **Delete [ ]** State: _______ **Add [ ]** **Delete [ ]**
State: _______ **Add [ ]** **Delete [ ]** State: _______ **Add [ ]** **Delete [ ]**
State: _______ **Add [ ]** **Delete [ ]** State: _______ **Add [ ]** **Delete [ ]**
State: _______ **Add [ ]** **Delete [ ]** State: _______ **Add [ ]** **Delete [ ]**

___ **Single State** (list the state) ________________________________ **Add [ ]** **Delete [ ]**

For each state you are serving, **of which you are only serving a selected county(s)**, please list the state (using the two letter state abbreviation) followed by the *selected county(s)* you wish to add or delete:

State, County: ________________________________ **Add [ ]** **Delete [ ]**
State, County: ________________________________ **Add [ ]** **Delete [ ]**
State, County: ________________________________ **Add [ ]** **Delete [ ]**
State, County: ________________________________ **Add [ ]** **Delete [ ]**
State, County: ________________________________ **Add [ ]** **Delete [ ]**
State, County: ________________________________ **Add [ ]** **Delete [ ]**
State, County: ________________________________ **Add [ ]** **Delete [ ]**

For each state you are serving, **of which you are NOT serving an entire county(s)**, please list the state (using the two letter state abbreviation) followed by the *selected zip code(s)* you wish to add or delete:

State, Zip Code: _________ **Add [ ]** **Delete [ ]** State, Zip Code: _________ **Add [ ]** **Delete [ ]**
State, Zip Code: _________ **Add [ ]** **Delete [ ]** State, Zip Code: _________ **Add [ ]** **Delete [ ]**
State, Zip Code: _________ **Add [ ]** **Delete [ ]** State, Zip Code: _________ **Add [ ]** **Delete [ ]**
State, Zip Code: _________ **Add [ ]** **Delete [ ]** State, Zip Code: _________ **Add [ ]** **Delete [ ]**
State, Zip Code: _________ **Add [ ]** **Delete [ ]** State, Zip Code: _________ **Add [ ]** **Delete [ ]**
State, Zip Code: _________ **Add [ ]** **Delete [ ]** State, Zip Code: _________ **Add [ ]** **Delete [ ]**
State, Zip Code: _________ **Add [ ]** **Delete [ ]** State, Zip Code: _________ **Add [ ]** **Delete [ ]**

**P. ___ Add or Delete Service Locations**

**Location Address:** ____________________________________________ **Add [ ]** **Delete [ ]**
____________________________________________
____________________________________________

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**Primary Contact Information:**

Contact Name: ________________________________
Phone: (____)______-___________ Toll Free #: (____)_____-_________
Fax: (____)_____ -_____________ TTY: (____)____ -_____________
Email: ________________________________________

**Beneficiary Contact Information:**

Contact Name: ________________________________
Phone: (____)______-___________ Toll Free #: (____)_____-_________
Fax: (____)_____ -_____________ TTY: (____)____ -_____________
Email: ________________________________________

**Preferred Impairment Groups Served at This Location:**

Impairment Group: _______________________________________ **Add [ ] Delete [ ]**
Impairment Group: _______________________________________ **Add [ ] Delete [ ]**
Impairment Group: _______________________________________ **Add [ ] Delete [ ]**
Impairment Group: _______________________________________ **Add [ ] Delete [ ]**
Impairment Group: _______________________________________ **Add [ ] Delete [ ]**
Impairment Group: _______________________________________ **Add [ ] Delete [ ]**
Impairment Group: _______________________________________ **Add [ ] Delete [ ]**

**Services Offered at This Location:**

Service: _______________________________________ **Add [ ] Delete [ ]**
Service: _______________________________________ **Add [ ] Delete [ ]**
Service: _______________________________________ **Add [ ] Delete [ ]**
Service: _______________________________________ **Add [ ] Delete [ ]**
Service: _______________________________________ **Add [ ] Delete [ ]**
Service: _______________________________________ **Add [ ] Delete [ ]**
Service: _______________________________________ **Add [ ] Delete [ ]**
Service: _______________________________________ **Add [ ] Delete [ ]**
Service: _______________________________________ **Add [ ] Delete [ ]**

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**Q. ___ Changes to Your Banking Information**

** **Please Note:** Changes to your EN's banking information may only be made by the Signatory Authority or an Authorized Negotiator listed in your contract. Unlike other contract changes, this request to change your banking formation must be made via fax or direct mail, and it must include a new ACH Vendor Payment Form (available at www.yourtickettowork.com/payment_options). **This ACH form must be signed by a representative of your bank.**

Please complete the following statement, which will serve as your request to change your banking information:

**I ____________ (name), _____________ (title), request that my Employment Network's banking information be changed, according to the information on the attached ACH Vendor Payment Form.**

**I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.**

**EN Name:** ______________________
**EIN:** ______________________
**Your Name:** ______________________
(Must be current Sig. Authority, Primary Contact, or Authorized Negotiator)
**Title:** ______________________
**Signature:** ______________________
**Date of Request:** ______________________

**Tips for completing the ACH Vendor Payment Form:**

- The ACH form consists of three sections, the first of which, titled "Agency Information" is already completed.
- The second section, titled Payee/Company Information, is the section in which you should fill in your EN's information. In the box labeled "Contact Person Name," your name should be both written **AND** signed.
- The third section, Financial Institution Information, is the section that should be completed and signed by a representative of your bank.

The information provided by the offeror on this form is for government use only for this requirement, to facilitate the electronic payment from SSA to the EN contractor and **will not** be released to entities outside of MAXIMUS, SSA, or your designated financial institution.

## Privacy Act Statement

### Collection and Use of Personal Information

Section 1148, of the Social Security Act, as amended, authorizes us to collect this information. The information is needed to permit the Social Security Administration (SSA) to verify eligibility for payment. The information you furnish on this form is voluntary. However, failure to provide all or part of the information requested on this form could prevent receipt of payment.

We rarely use the information you supply for any purpose other than verifying eligibility for payment. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to: (1) to enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage; (2) to comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and Department of Veteran Affairs); (3) to make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; (4) to State agencies or Employment Networks having an approved business arrangement with SSA to perform vocational rehabilitation services for disability beneficiaries and recipients; and (5) to facilitate statistical research, audit or investigative activities necessary to assure the integrity of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, state or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally funded and administered benefit programs and for repayment of payments or delinquent debts under these programs.

A complete list of routine uses for this information is available in Systems of Record Notices 60-0295 and 60-0300. The notices, additional information regarding this form, and information regarding our programs and systems, are available on-line at www.socialsecurity.gov or at your local Social Security office.

**Paperwork Reduction Act Statement** - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. SEND THE COMPLETED FORM TO MAXIMUS TICKET TO WORK, PO BOX 1433, ALEXANDRIA, VA 22313, OR FAX TO 703-683-3289.** *You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***