

## Seneca Nation Disability Services Information Change Form

Change Requested: \_\_\_\_\_ Phone \_\_\_\_\_ Mailing Address  
 (check all that apply) \_\_\_\_\_ Name \_\_\_\_\_ Payee  
 \_\_\_\_\_ Physical Address

**Please provide documentation for any change(s) (except phone) when submitting this form. You must also update in the Clerk's Office before these changes can be made. Failure to do so will result in your check being held or discontinued.**

Name: (print) \_\_\_\_\_ DOB: \_\_\_\_\_ Roll #: \_\_\_\_\_

Name changed to: (if applicable) \_\_\_\_\_

Phone/Contact Number: \_\_\_\_\_

Previous Physical Address: \_\_\_\_\_

New Physical Address: \_\_\_\_\_  
*(Proof of Residence Required)*

Is this also your mailing address? \_\_\_ YES \_\_\_ NO

Previous Mailing Address: \_\_\_\_\_

New Mailing Address: \_\_\_\_\_

Previous Payee: \_\_\_\_\_  
 Address/Phone: \_\_\_\_\_

New Payee: \_\_\_\_\_  
 Address/Phone: \_\_\_\_\_

\*\*Checks will be mailed to the Payee assigned by the Issuing Agency. Any other arrangements will be made at the discretion of the Disability Services Staff.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Payee/Rep:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Received on:	By:	Change submitted:
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