



## **DD PSW, IC-PSW or other Individual Provider Change of Information Request Form INSTRUCTIONS**

For providers who have been successfully enrolled and/or have a SPD/DHS provider number assigned, the attached form and process should be used to request an update or change to the provider's DHS provider record information. Multiple sections or changes can be requested on a single form; just indicate by checking the appropriate box(es) on the form for changes requested.

**This Change of Information Request form is for changes ONLY to the DHS Provider record for the associated individual provider types/specialties related to providing ODDS In-Home or Community services to individuals with I/DD.**

This request form *does not* make changes to the provider's record related to any APD funded services, their profile in the Oregon Home Care Commissions Referral & Registry system, nor does it change the provider's eXPRS user enrollment profile.

1. Providers, CDDPs and Brokerages may soon access the ***DD PSW or Individual In-Home Provider Change of Information Request*** form from:
  - a. eXPRS Help Menu
  - b. CDDPs/Brokerages
  - c. PSW forms website links
  - d. DHS Forms website
  - e. Oregon Home Care Commission (OHCC)
  
2. Providers, CDDPs or Brokerages can complete the ***DD PSW or Individual In-Home provider Change of Information Request*** form, indicating what information is requested to be changed/updated for the provider.
  - a. **TYPE OF ACTION:** please check the appropriate box(s) for the type of change(s) to the provider record being requested. Providers may request multiple changes at one time using a single form.

- b. **CURRENT PROVIDER NAME:** this is the name that is currently listed on the provider's DHS provider record.
  - c. **PROVIDER NUMBER:** list the provider's 6-digit SPD provider number for the record being requested.
  - d. **CHANGE OF PROVIDER NAME, SSN or TIN:** If a change to information in this section is being requested, check this box, and add the NEW information to be added to the provider's record.
    - **PLEASE NOTE:** A requested change to any of this information will necessitate a recheck of the provider's identity, per ACA regulations.
    - \*\* The provider MUST attach & submit copies of their new Social Security card or other tax documentation from the IRS verifying the new name or tax number information for the provider.**
  - e. **CHANGE OF PROVIDER ADDRESS:** If a change to information in this section is being requested, check this box, and add the NEW information to be added to the provider's record.
  - f. **CHANGE/ADD PROVIDER EMAIL:** If a change to information in this section is being requested, check this box, and add the NEW information to be added to the provider's record.
  - g. **UPDATE CRIMINAL HISTORY CHECK INFORMATION:** A CDDP or Brokerage would complete the form and this section if new or updated CHC Information is being submitted. CDDPs or Brokerages would check this box, and add the NEW information to be added to the provider's record, and submit to DHS.
  - h. **ADDITIONAL INFORMATION:** Please indicate which programs (CDDP, Brokerage, or CIIS) for the client(s) for whom the provider is working. Also add additional comments, as necessary.
  - i. **SIGNATURE OF PERSON SUBMITTING FORM:** The person completing the form (either the provider themselves, or a representative from a CDDP or Brokerage) signs and dates the form.
3. When completed, send the ***DD PSW or Individual In-Home Provider Change of Information Request*** form and other documents must be sent to ***BOTH:***

- DHS Provider Relations Unit AND
- TNT Fiscal Intermediary

**To Send to the DHS Provider Relations Unit:**

**BY EMAIL:**

- a. Send an email to [psw.enrollment@state.or.us](mailto:psw.enrollment@state.or.us) requesting a secure email.
- b. DHS will reply with a secure email to the requestor.
- c. The requestor then replies to that secure email received from DHS, attaching the completed form and other documents and sends.

**BY FAX:**

Fax the completed form and other documents to:

Attn: Provider Relations Unit

Fax number: **503-947-5357**

**BY US POSTAL MAIL:**

- Mail the completed form and other documents to:

**Provider Relations Unit**

**P. O. Box 14990**

**Salem, OR 97309-5083**

**→ PLEASE NOTE:** As stated above, some requested changes will require a re-check of the provider's identity, per federal ACA regulations. If the provider does not pass the ACA validation re-checks, they will be notified that they have not passed, that they are no longer "approved to work" and that their provider record with DHS has been/will be closed.

**Changes that do NOT require ACA validation re-checks:**

- d. Changes to address, phone, email, or update of CHC approval.

**Changes that DO require ACA validation re-checks:**

- e. Change of name (such as due to marriage/divorce).
- f. Change to Social Security number.
- g. Change or addition of another Tax Identification number.