



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

For individual providers who work with/for clients receiving ODDS In-Home or Community Services

**Type of Action(s):**

- Change of Provider Name or SSN/TIN  
*\* documentation of new name, SSN/TIN required*
- Change of Provider Address
  Change/Add Other Information
- Update CHC Information/Date

**Current Provider Name:**

**Provider #:**

**CHANGE PROVIDER NAME, SSN or TIN:** New information below

<b>LAST NAME:</b>		<b>FIRST NAME:</b>		<b>MI:</b>
<b>DOB: (required)</b>		<b>SSN: (required)</b>		<b>TIN: (if different than SSN)</b>

**CHANGE PROVIDER ADDRESS:** New address information below:

Type of address to be changed:  Physical

<b>STREET/PO Box:</b>		<b>CITY:</b>
<b>COUNTY:</b>	<b>STATE:</b>	<b>ZIP +4:</b>

**CHANGE PROVIDER ADDRESS:** New address information below:

Type of address to be changed:  Mailing  Same as Physical

<b>STREET/PO Box:</b>		<b>CITY:</b>
<b>COUNTY:</b>	<b>STATE:</b>	<b>ZIP +4:</b>

**CHANGE/ADD PROVIDER PHONE NUMBER:** New information below

<b>PHONE NUMBER:</b>	<b>PHONE TYPE:</b>
----------------------	--------------------

**CHANGE/ADD PROVIDER EMAIL:** New information below

**Email Address:**

**UPDATE Provider's Criminal History Check (CHC) INFORMATION:** New information below

<b>Date of NEW CHC Fitness Determination:</b> (Attach copy of CHC notice received)	<input type="checkbox"/> Restricted to client; List Client's Prime:
	<input type="checkbox"/> Career
<b>Level of CHC Approval:</b> <input type="checkbox"/> Adult <input type="checkbox"/> Seniors <input type="checkbox"/> Child	

<b>Provider is working for clients associated with:</b>	
<input type="checkbox"/> CDDP	CDDP Name:
<input type="checkbox"/> Brokerage	Brokerage Name:
<input type="checkbox"/> CIIS	
<b>Comments/Notes/Additional Information:</b>	
<b>SIGNATURE OF PERSON SUBMITTING INFORMATION:</b>	<b>DATE:</b>

Send completed & signed form + any additional documentation as needed to:

**DHS Provider Relations Unit**

**BY EMAIL:** [psw.enrollment@state.or.us](mailto:psw.enrollment@state.or.us)

**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**