

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

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Type of Action(s): Change of Provider Name or SSN/TIN * documentation of new name, SSN/TIN required		☐ Change of Provider Address☐ Update CHC Information/Date			☐ Change/Add Other Information			
Cı	Current Provider Name:					Provider #:		
☐ CHANGE PROVIDER NAME, SSN or TIN: New information below								
	LAST NAME:		FIRST NAME:			MI:		
	DOB: (required) SSN: (required)		ed)		TIN: (if different than SSN)			
CHANGE PROVIDER ADDRESS: New address information below:								
	Type of address to be chan	ged: D	hysical					
	STREET/PO Box:			CITY	CITY:			
	COUNTY:	COUNTY:		ZIP -				
	CHANGE PROVIDER ADDRESS: New address information below:							
Type of address to be changed: Mailing Same as Physical								
	STREET/PO Box:			CITY	CITY:			
	COUNTY:		STATE:	ZIP -	+4:			
	CHANGE/ADD PROVIDER	R PHONE N	IUMBER: New inform	ation k	pelow			
	PHONE NUMBER:			PHO	NE TYPE:			
	CHANGE/ADD PROVIDER EMAIL: New information below							
	Email Address:							
☐ UPDATE Provider's Criminal History Check (CHC) INFORMATION: New information below								
	Date of NEW CHC Fitness Determination: (Attach copy of CHC notice received) Restricted to client; List Client's Prime: Career							
	Level of CHC Approval: Adult Seniors Child							

Provider is working for clients associated with:								
CDDP	CDDP Name:							
Brokerage	Brokerage Name:							
CIIS								
Comments/Notes/Additional Information:								
SIGNATURE OF PERSON SUBMITTING INFORMATION: DATE:								

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

DHS Provider Relations Unit

BY EMAIL: 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