DHS
Oregon Department of Human Services

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 ☐ 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

LAST NAME:	**FIRST NAME:**	**MI:**

DOB: *(required)*	**SSN:** *(required)*	**TIN:** *(if different than SSN)*

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

Type of address to be changed: ☐ **Physical**

STREET/PO Box:		**CITY:**
COUNTY:	**STATE:**	**ZIP +4:**

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

Type of address to be changed: ☐ **Mailing** ☐ **Same as Physical**

STREET/PO Box:		**CITY:**
COUNTY:	**STATE:**	**ZIP +4:**

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

PHONE NUMBER:	**PHONE 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

SSN = Social Security Number
TIN = Tax Identification Number

Provider is working for clients associated with:	
☐ CDDP	**CDDP Name:**
☐ Brokerage	**Brokerage Name:**
☐ CIIS	

Comments/Notes/Additional Information:

SIGNATURE OF PERSON SUBMITTING INFORMATION:	DATE:

SSN = Social Security Number
TIN = Tax Identification Number