



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:
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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)	<input type="checkbox"/> Restricted to client; List Client's Prime:
	<input type="checkbox"/> Career
Level of CHC Approval: <input type="checkbox"/> Adult <input type="checkbox"/> Seniors <input type="checkbox"/> Child	

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