

Developmental Disabilities Personal Support Worker or Independent Provider Change of Information Form

Change type:

- Provider record
- Express Payment & Reporting
System (eXPRS) user account

Check all that apply:

- Change of provider address
- Change of email address
- Change of phone number

(Any SSN, name, DOB changes **must** submit new provider enrollment application and agreement (PEAA) or UEF.)

Provider name: _____			
<i>(required)</i>	First name	Last name	Middle initial
Provider number: _____		Date of birth <i>(required)</i> : _____	
Social Security Number (SSN) <i>(required)</i> : _____			
eXPRS user account log in: _____			
Change of email: _____		Change of phone: _____	
Change of physical address			
Address: _____		City: _____	
County: _____	State: _____	ZIP code™+4: _____	
Change of mailing address <i>(if different than physical address)</i>			
Address: _____		City: _____	
County: _____	State: _____	ZIP code™+4: _____	
Comments, notes or additional information <i>(including submitting Community Developmental Disabilities Program (CDDP) or brokerage information)</i>			

Provider signature *(required)*

Date *(required)*

Send completed and signed form via email to: PSW.Enrollment@dhsosha.state.OR.US

*Requests are limited to those listed on this form. Additional changes will require a new UEF or PEAA.