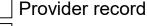


Developmental Disabilities Personal Support Worker or Independent Provider

Change of Information Form

Change type:



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:			
(required)	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 (if different than physical address)			
Address:			City:
County:		State:	ZIP code™+4:
Comments, notes or additional information (including submitting Community Developmental Disabilities Program (CDDP) or brokerage information)			

Provider signature (required)

Date (required)

Send completed and signed form via email to: <u>PSW.Enrollment@dhsoha.state.OR.US</u> *Requests are limited to those listed on this form. Additional changes will require a new UEF or PEAA.