DHS | Oregon Department of Human Services
OFFICE OF DEVELOPMENTAL DISABILITIES SERVICES

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: _____
(*required*) First name Last name Middle initial

Provider number: _____ Date of birth (*required*): _____

Social Security Number (SSN) (*required*): _____

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: PSW.Enrollment@dhsoha.state.OR.US
*Requests are limited to those listed on this form. Additional changes will require a new UEF or PEAA.

Print Reset

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