Provider Change Form

Rhode Island Department of Human Services
Office of Child Care
25 Howard Avenue, LP Bldg. 3rd Floor
Cranston, R.I. 02920
(401) 462-6877

Use this form to report CHANGES in Name, Address, Phone number, or Household members. DO NOT write the information on your billing invoice.

Provider ID: _____ Provider Name: _____

Provider's Address On File: _____
Street Apt.#/Suite City State Zip

☐ Address Change Date of Change: __ __ / __ __ / __ __ __ __

_____
Street Apt.#/Suite City State Zip

You must submit verification (utility bill – or, for licensed providers, a DHS license) with your new address on it.

☐ Name Change New Name: _____

You must submit verification of your name change with Social Security (you must send a copy of your new Social Security Card in your new name) and submit another W-9 with your new name.

☐ Telephone Number Change New Number: __ __ __- __ __ __- __ __ __ __

You must submit a phone bill with the new number, your name and your address on the bill.

☐ Email Address Change New Email: _____

☐ Household Member(s) Change
All new household members will be screened through the Office of the Attorney General & the Department of Children, Youth and Families.

NAME (Last, First, MI)	Sex	Date of Birth	SSN	Date Moved In

I understand the penalty for hiding or giving false information. To the best of my knowledge, I hereby certify that all the information I have given and written is true and correct.

_____ _____
Date Provider's Signature

Please complete this form and mail it to: Rhode Island Department of Human Services
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