State of Illinois
Department of Human Services - Division of Developmental Disabilities

PROVIDER / AGENCY / PAYEE INFORMATION UPDATE FORM

Please use this form to notify the Illinois Department of Human Services (DHS), Division of Developmental Disabilities (DDD) when there are any changes in provider, agency or payee contact information. This form is to facilitate notification to all internal DDD bureaus to update and maintain accurate contact information. Please mail or fax the Provider/Agency/Payee Information Update form as specified below. It is incumbent upon the providers to provide updated information within 5 days of a change, including your email.

Provider / Agency Name

Provider / Agency FEIN (9 Digits)

Provider / Agency ID Number (4 Digits)

( ) Phone Number

( ) Fax Number

Street Address

City State Zip Code

***Executive Director / CEO / Primary Contact Name (Required)**

***Secondary Contact Name (Required)**

Executive Director / CEO / Primary Contact Title (Required)

Secondary Contact Title (Required)

Executive Director / CEO / Primary Contact Email Address (Required)

Secondary Contact Email Address (Required)

( ) **Extension** **Executive Director / CEO / Primary Contact Phone Number**

( ) **Extension** **Secondary Contact Phone Number**

2. Identify ALL Services & Supports the Provider / Agency Delivers (Check All that Apply):

- ☐ Community Integrated Living Arrangements (CILA)
- ☐ Children's/Other Residential
- ☐ Community Day Services
- ☐ Other Day Services (e.g., Supported Employment Program - SEP)
- ☐ Home Based Services (HBS) Self-Direction Assistance
- ☐ Intermediate Care Facility/Individuals with Intellectual Disabilities(ICF/IID)
- ☐ Independent Service Coordination (ISC)
- ☐ Skilled Nursing Facility/Pediatrics (SNF/PED)
- ☐ Approved Provider for Direct Support Person (DSP), Qualified Intellectual Disability Professional (QIDP), etc. Training
- ☐ Provider of Other Support Services (e.g.: Therapy, Counseling, Behavior Intervention, etc.)
- ☐ Provider of Other Services (Please list): _____

3. PAYEE Contact & Address Verification: (Fill in this section ONLY if payments for services from DHS/DDD are sent to a payee different than the actual provider / agency listed above):

Payee Name

Payee FEIN (9 Digits)

( ) Phone Number

Street Address

City State Zip Code

4. Submit the Agency Update Information Form to:
DHS Division of Developmental Disabilities
Provider Enrollment
600 East Ash Street, Building 400, 2nd Floor, Mail Stop 2S
Springfield, IL 62703 OR FAX TO: 217-557-7251