



California Access to Recovery Effort (CARE)

Revised June 2013

ORGANIZATION INFORMATION CHANGE

Section 1 (Required for all changes)		
Organization Name	CARE Provider Number(s):	
Reason for submitting form: <input type="checkbox"/> Organizational change <input type="checkbox"/> Address, phone or email change or addition <input type="checkbox"/> Delete a service type		
Section 2 (Required for organizational changes) *A NEW PAYEE DATA RECORD IS REQUIRED FOR CHANGES IN SUBSECTIONS A OR C*		
A. <input type="checkbox"/> Organization Name Change: Old name: New name:		
B. <input type="checkbox"/> Change in Administrator or Director Old name: New name:		
C. <input type="checkbox"/> Organizational Status Change Old status: <input type="checkbox"/> sole proprietor <input type="checkbox"/> partnership <input type="checkbox"/> for-profit corp <input type="checkbox"/> nonprofit corp New status: <input type="checkbox"/> sole proprietor <input type="checkbox"/> partnership <input type="checkbox"/> for-profit corp <input type="checkbox"/> nonprofit corp		
Section 3 (Required for address, phone, or email changes) *A NEW PAYEE DATA RECORD IS REQUIRED FOR CHANGES IN SUBSECTION B*		
A. <input type="checkbox"/> Administrative Address Change Old address: _____ Old phone and/or fax no: _____ New address: _____ New phone and/or fax no: _____		
B. <input type="checkbox"/> Mailing Address Change Old address: _____ Old phone and/or fax no: _____ New address: _____ New phone and/or fax no: _____		
C. <input type="checkbox"/> Service Address Change (Provider Number: _____) Old address: _____ Old phone and/or fax no: _____ New address: _____ New phone and/or fax no: _____ Treatment providers must also submit evidence they have been ADP-certified at the new service location.		
D. Email change (specify which): <input type="checkbox"/> Public provider directory email (for client referral purposes and contact by other CARE providers): Old email address: _____ New email address: _____ <input type="checkbox"/> Primary email address for ADP to contact (executive director or program director) Old email address: _____ New email address: _____ <input type="checkbox"/> Additional email address for ADP to contact (counselors, intake staff, etc.): Name: _____ Title: _____ Email address: _____		
Section 4 (Required for all changes)		
Authorized Signature: _____	Title: _____	Date: _____

Return completed form to Sue Heavens by fax: (916)445-0846, email: sue.heavens@dhcs.ca.gov, or US mail: Department of Health Care Services, CARE Unit, MS 2601, PO Box 997413, Sacramento, CA 95899-7413. If you have questions or need additional information, please contact Ms. Heavens at (916) 445-0323

*The Payee Data Record form can be downloaded from the CARE website under "Provider Info."

Changes must be approved by ADP in advance of program implementation. Changes affecting payments (name change, status change, or change in mailing address) may delay reimbursement.