



# California Access to Recovery Effort

(CARE) Revised June 2013

## ORGANIZATION INFORMATION CHANGE

<b>Section 1</b> (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	
<b>Section 2</b> (Required for organizational changes) <b>*A NEW PAYEE DATA RECORD IS REQUIRED FOR CHANGES IN SUBSECTIONS A OR C*</b>	
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	
<b>Section 3</b> (Required for address, phone, or email changes) <b>*A NEW PAYEE DATA RECORD IS REQUIRED FOR CHANGES IN SUBSECTION B*</b>	
A. <input type="checkbox"/> Administrative Address Change Old address: <span style="float: right;">Old phone and/or fax no:</span> New address: <span style="float: right;">New phone and/or fax no:</span>	
B. <input type="checkbox"/> Mailing Address Change Old address: <span style="float: right;">Old phone and/or fax no:</span> New address: <span style="float: right;">New phone and/or fax no:</span>	
C. <input type="checkbox"/> Service Address Change (Provider Number:                    ) Old address: <span style="float: right;">Old phone and/or fax no:</span> New address: <span style="float: right;">New phone and/or fax no:</span> 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: <span style="float: right;">New email address:</span> <input type="checkbox"/> Primary email address for ADP to contact (executive director or program director) Old email address: <span style="float: right;">New email address:</span> <input type="checkbox"/> Additional email address for ADP to contact (counselors, intake staff, etc.): Name: <span style="margin-left: 100px;">Title:</span> <span style="float: right;">Email address:</span>	
<b>Section 4</b> (Required for all changes)	
Authorized Signature:	Title: <span style="float: right;">Date:</span>

Return completed form to Sue Heavens by fax: (916)445-0846, email: [sue.heavens@dhcs.ca.gov](mailto: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.**