pennsylvania
DEPARTMENT OF HUMAN SERVICES
OFFICE OF LONG TERM LIVING

Participant Name	Employer Name	Employee Name

Direct Care Worker Change of Information Form

Address/Name Change (Please Print)	
Previous Name:	New Name:
Previous Address Street:	New Address Street:
Previous City: State: Zip Code:	New City: State: Zip Code:
PreviousTWP/Borough/SchoolDistrict:	New TWP/Borough/School District:
Name of participant for whom you work:	Participant's ID#:

If you are completing this form because of a name change, please send this form and a copy of your new Social Security card to Public Partnerships LLC. We will need a copy of this card, along with this form, signed and completed, before the change will take effect.

Worker Signature _____ Date _____

FAX TO: 1-855-858-8158 or EMAIL TO: padpw-oltl@pcgus.com

NOTE: Information provided on this form is confidential and is treated as such. Completion of this data is voluntary and will not affect your employment status. Identification can be declared at any time prior to, or if applicable, after hire.