



Provider File Action Request

IMPORTANT: Before adding a new provider, you must complete a thorough search of the provider file.

1. UPDATE ACTION <input type="checkbox"/> Add <input type="checkbox"/> Change		2. SSPS /PROVIDER NUMBER		3. COUNTY	
4. STATUS (CHECK ONE) <input type="checkbox"/> 0 Open <input type="checkbox"/> 1 Closed <input type="checkbox"/> 2 Deceased <input type="checkbox"/> 3 Lien/Garnishment (for use by Finance Division only) <input type="checkbox"/> 4 Contact SSPS Control before using Status 4 provider Also contact SSPS Control to request Status 4 designation. <input type="checkbox"/> 5 Open and receiving direct deposit (for SSPS Control use only)					
5. TELEPHONE NUMBER (INCLUDE AREA CODE)			6. CELL NUMBER (INCLUDE AREA CODE)		
7. FAX NUMBER (INCLUDE AREA CODE)			8. CONTACT PREFERENCE <input type="checkbox"/> Mail <input type="checkbox"/> Email		
9. EMAIL ADDRESS					
10. TYPE OF AGENCY/PROVIDER (OVER)			11. PAYEE PROVIDER REF NUMBER		
<p>You must enter either the Social Security Number (SSN) or Employer Identification Number (EIN). Individuals use Social Security Number (SSN); sole proprietors may use either Employer Identification Number (EIN) or SSN; Limited Liability Companies (LLCs), corporations and partnerships must have an EIN.</p>					
12. SSN		OR		13. EIN	
14. MAILING NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL) FOR TAX DOCUMENTS				Complete Item 15 only if the Information is different from Item 14 above	
BUSINESS NAME IF DIFFERENT FROM ABOVE					
(1) ADDRESS					
(2) ADDRESS					
CITY					
STATE		ZIP CODE			
15. BILLING NAME IF DIFFERENT (LAST NAME, FIRST NAME, MIDDLE INITIAL - OR BUSINESS NAME)				Complete Item 15 only if the Information is different from Item 14 above	
BUSINESS NAME IF DIFFERENT FROM ABOVE					
(1) ADDRESS					
(2) ADDRESS					
CITY					
STATE		ZIP CODE			
15B. IN CASE OF EMERGENCY (ICE) CONTACT NAME				PHONE NUMBER W/AREA CODE	
ADDRESS					
REQUESTOR INFORMATION					
16. REQUESTOR'S NAME		17. TELEPHONE NUMBER		18. RU NUMBER	19. DATE
PRIMARY PROVIDER INFORMATION		SECONDARY PROVIDER INFORMATION		OTHERS IN HOME (ADD ADDITIONAL PAGES IF NECESSARY)	
FULL NAME		FULL NAME		FULL NAME	
GENDER		GENDER		GENDER	

DATE OF BIRTH		DATE OF BIRTH		DATE OF BIRTH	
RACE	ETHNICITY	RACE	ETHNICITY	RACE	ETHNICITY
MARITAL STATUS		MARITAL STATUS		MARITAL STATUS	

ITEM 3: COUNTY CODE LIST

CODE	COUNTY	CODE	COUNTY	CODE	COUNTY	CODE	COUNTY
1	Adams	11	Franklin	21	Lewis	31	Snohomish
2	Asotin	12	Garfield	22	Lincoln	32	Spokane
3	Benton	13	Grant	23	Mason	33	Stevens
4	Chelan	14	Grays Harbor	24	Okanogan	34	Thurston
5	Clallam	15	Island	25	Pacific	35	Wahkiakum
6	Clark	16	Jefferson	26	Pend Oreille	36	Walla Walla
7	Columbia	17	King	27	Pierce	37	Whatcom
8	Cowlitz	18	8 Kitsap	28	San Juan	38	Whitman
9	Douglas	19	Kittitas	29	Skagit	39	Yakima
10	Ferry	20	Klickitat	30	Skamania	40	Out-of-state

ITEM 11: TYPE OF AGENCY/PROVIDER

CODE NAME

AA	Adoption Agency
AC	Attendant Care
AF	Adult Family Home
AG	Area Agency on Aging
AL	Alternative Living
AP	Adoptive Home
AT	Attorney at Law
BH	Boarding Home (Assisted Living, ARC, and EARC)
CA	COPES Agency Provider
CB	Commercial Business
CC	Child Care Center
CD	Child Development and Mental Retardation Center University of Washington (CDMRC)
CH	Child Care Family Home, Licensed
CI	Child Care In-Home
CL	Client Payee
CP	COPES Individual Provider
CS	Child Study/Guidance Clinic
CT	Court (County/Municipal/Juvenile)
CU	Community College/University
CX	Chiropractor
DE	Dentist/Orthodontist
DG	DD Group Home
DV	Developmental Center
FF	Family Foster Home (DCFS)
FG	Foster Group Home
FP	Family Planning Clinic
FR	Family Resource Coordinator
FS	Family Support Parent Provider
GS	Group Shelter/Receiving Home
HA	Health Agency
HO	Home Aid

CODE NAME

HS	Hospital
IC	Intermediate Care Facility (ICF)
IL	Independent Living
MA	Maternity Home
MC	Mental Health Center
MH	Mental Health Hospital
NA	Not Active
ND	Nurse Delegation
OP	Optometrists/Optician
OS	Other Social Service Agency (non-DSHS)
PC	Personal Care Provider
PF	Private Agency Foster Home
PG	Public/Government Agency
PH	Physician/Surgeon/Ophthalmologist
PI	Private Individual
PP	Protective Payee
PT	Physical Therapist/Occupational Therapist
PS	Private Group Service Agency
RC	Crisis Residential Center
RE	Respite/Emergency Care Provider
RL	Relative
RT	Residential Treatment Facility
RU	Reporting Unit (CSO, DCFS, FSO)
SC	School
SH	Shelter/Receiving Home (Family)
SK	Skilled Nursing Facility (SNF)
SL	Supported Living
SP	Social Worker/Psychologist/Psychiatrist
TR	Transportation Agency
VO	Volunteer Individual/Organization
VR	Vocational Rehabilitation

NOTE: Facility coded as CF" Congregate Care Facility" should be changed to BH "Boarding Home.

MAILING NAME - This must be the legal name associated with the tax number entered in item 12 or 13.

ADDRESS – This is where tax documents are mailed at year end. If there isn't a billing name and address, this is also where other mail is sent.

BILLING NAME – If this field is used, it must be either the mailing name or business name from item 14.