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|  | **Assisted Living FacilityInformation Changes** | FACILITY NAME |
| LICENSE NUMBER |
| **Did facility information change?** **[ ]  Yes** **[ ]  No If yes, complete applicable change(s) below.** |
| NEW FACILITY NAME (ATTACH COPY OF WASHINGTON (WA) BUSINESS LICENSE SHOWING REGISTERED TRADE NAME) |
| MAILING ADDRESS CITY STATE ZIP CODE |
| FACILITY NUMBER (WITH AREA CODE) | CONFIDENTIAL FAX NUMBER (WITH AREA CODE) |
| EMAIL ADDRESS | WEBSITE |

|  |
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| **Did Entity Information change? [ ]  Yes [ ]  No If yes, complete applicable change(s) below.** |
| NEW LEGAL ENTITY NAME (ATTACH COPY OF WA BUSINESS LICENSE AND INTERNAL REVENUE SERVICE EIN VERIFICATION DOCUMENTATION) |
| MAILING ADDRESS CITY STATE ZIP CODE |
| PHONE NUMBER (WITH AREA CODE) | FAX NUMBER (WITH AREA CODE) | CELL PHONE NUMBER (WITH AREA CODE) |

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| **Did Administrator change? [ ]  Yes [ ]  No If yes, all information below is required.** |
| [ ]  New Administrator meets qualifications in Chapter 388-78A WAC. |
| OUTGOING ADMINISTRATOR NAME | END DATE |
| INCOMING ADMINISTRATOR NAME | SOCIAL SECURITY NO. | DATE OF BIRTH | START DATE |
| **Signature of Licensee** |
| **Form submitted without signature will not be processed.** |
| **I attest that all above changes are true and accurate. Forms without a signature will be rejected.** | **SIGNATURE OF LICENSEE** DATE |
| **Please email completed form to** **RCSBOA@dshs.wa.gov****.** |
| **BOA Use Only** |
|  ENTERED BY: DATE ENTERED[ ]  FMS  |
|  DATE LICENSE MAILEDNew license required (facility name change)? [ ]  Yes [ ]  No  |
|  DATE CONTRACTS NOTIFIEDContracts notified of changes (facility name or address)? [ ]  Yes [ ]  No  |
|  DATE RETURNED TO LICENSEE[ ]  Not processed; returned to **Licensee**.  |