|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Supported Living Information Changes** | | | | | PROVIDER NAME | | |
| CERTIFICATION NUMBER | | |
| COUNTY | | |
| **Did Provider Information change?  Yes  No If yes, complete applicable change(s) below.** | | | | | | | | |
| NEW PROVIDER NAME (ATTACH COPY OF WASHINGTON (WA) BUSINESS LICENSE SHOWING REGISTERED TRADE NAME AND INTERNAL REVENUE SERVICE EIN VERIFICATION DOCUMENTATION) | | | | | | | | |
| MAILING ADDRESS CITY STATE ZIP CODE | | | | | | | | |
| STREET ADDRESS CITY STATE ZIP CODE | | | | | | | | |
| PROVIDER NUMBER (WITH AREA CODE) | | CONFIDENTIAL FAX NUMBER (WITH AREA CODE) | | | | | CELL PHONE NUMBER (WITH AREA CODE) | |
| EMAIL ADDRESS | | | WEBSITE | | | | | |
| **Did Administrator change?  Yes  No If yes, all information below is required.** | | | | | | | | |
| **Please attach a letter from Service Provider authorizing change of Administrator.**  New Administrator meets qualifications in Chapter 388-101D WAC. | | | | | | | | |
| OUTGOING ADMINISTRATOR NAME (LAST, FIRST, MIDDLE) | | | | | | | | END DATE |
| INCOMING ADMINISTRATOR NAME (LAST, FIRST, MIDDLE) | | | | | | | | START DATE |
| SOCIAL SECURITY NO. | | | | | DATE OF BIRTH | | | |
| **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**](mailto:RCSBOA@dshs.wa.gov)**.** | | | | | | | | |
| **BOA Use Only** | | | | | | | | |
| ENTERED BY: DATE ENTERED  FMS | | | | | | | | |
| DATE FORM EMAILED  Change form e-mailed to SL FM | | | | | | | | |
| DATE RETURNED TO LICENSEE  Not processed; returned to **Service Provider**. | | | | | | | | |