State of Washington



Department of Social and Health Services

Division of Behavioral Health and Recovery

**APPLICATION FOR AGENCY NAME CHANGE**

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| **Current Agency Name:**  **Line 1:**  **Line 2:** (if any) |
| **Agency License Number:** |
| **New Agency Name: Line 1:**  **Line 2:**  (if any)  **Reason for Name Change:** |

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| Please attach a copy of your **Washington State Business License** that reflects the **NEW NAME** of the agency. The new name can be a new “trade name.” The business license number can be the same as under the old name.  RCW 19.80 requires all organizations conducting business in Washington State to register their business name and any trade name the organization intends to operate under. A trade name can be added or changed on the business license on the Department of Revenue website: [<http://bls.dor.wa.gov/forms/700028.pdf>l](http://www.dol.wa.gov/business/addtradenames.html). |

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| **Has a change in ownership occurred?** YES  \_\_\_\_\_\_\_ NO  \_\_\_\_\_\_\_  If yes, indicate date agency changed or will change ownership: **\_\_\_**\_   * For the current owner selling the agency, please fill out a Voluntary Certification Cancellation Request Form found at <https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/licensing-and-certification-behavioral-health-agencies> under Other Forms for Currently Licensed Agencies. * For the new owner buying the agency, please fill out an Initial Application for Behavioral Health Agency Licensure at <https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/licensing-and-certification-behavioral-health-agencies>.   State certification to provide services is not transferable to a new owner.  It is recommended that the seller and the buyer coordinate dates for continuity of care. |

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| **Signature of Administrator or Other Legal Representative:** | | **Date of signature:** |
| **Printed Name of Person Signing Form:** | | **Title:** |
| **Mailing Address of Person Signing Form:**    **City:**       **State:**       **Zip:** | | |
| **Telephone Number of Person Signing Form:**  (     ) | **Fax:**  (     ) | |
| **E-mail Address of Person Signing Form:** | | |

Return this Form by mail, fax, or email to:

Certification Provider Request Manager

Division of Behavioral Health and Recovery

Post Office Box 45330

Olympia, Washington 98504-5330

Phone: 360-725-3819; Fax: 360-725-2279

Email: [dbhrproviderrequests@dshs.wa.gov](mailto:dbhrproviderrequests@dshs.wa.gov)

If you need technical assistance regarding the name change approval process, or need a copy of any regulation cited in this request form, please contact the DBHR Certification Provider Request Manager.