Adult Family Home Information Changes

FACILITY NAME
LICENSE NUMBER

Facility Information

NEW FACILITY NAME			
MAILING ADDRESS	CITY	STATE	ZIP CODE
FACILITY NUMBER (WITH AREA CODE)	CONFIDENTIAL FAX NUMBER (WITH AREA CODE)	CELL PHONE NUMBER (WITH AREA CODE)	
EMAIL ADDRESS	WEBSITE		

Did specialty designations change? ☐ **Yes** ☐ **No**

	ADDED	ENDED	CHANGE ER / RM
Dementia	☐	☐	☐
Mental Health	☐	☐	☐
Developmental Disabilities	☐	☐	☐

Did Resident Manager change? ☐ **Yes** ☐ **No** **If yes, all information below is required.**

☐ New Resident Manager meets qualifications in Chapter 388-76 WAC.

OUTGOING RESIDENT MANAGER NAME			END DATE
INCOMING RESIDENT MANAGER 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 Adult Family Home Information Changes form to BAAU@dshs.wa.gov.

BAAU Use Only

ENTERED BY: ☐ FMS	DATE ENTERED
New license required (street address or specialties updated)? ☐ Yes ☐ No	DATE LICENSE MAILED
Contracts notified of changes (facility name or address)? ☐ Yes ☐ No	DATE CONTRACTS NOTIFIED
☐ Not processed; returned to Licensee.	DATE RETURNED TO LICENSEE