Washington State Department of Social & Health Services
Transforming lives

Assisted Living Facility Information Changes

FACILITY NAME
LICENSE NUMBER

Did facility information change? ☐ **Yes** ☐ **No** **If yes, complete applicable change(s) below.**

NEW FACILITY NAME (ATTACH LETTER FROM LICENSEE AND COPY OF 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

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 BAAU@dshs.wa.gov.

BAAU Use Only

ENTERED BY:

☐ FMS

DATE ENTERED

New license required (facility name change)? ☐ 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