



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.**

<input type="checkbox"/> 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

I attest that all above changes are true and accurate. Forms without a signature will be rejected.	SIGNATURE OF LICENSEE	DATE
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Please email completed Assisted Living Facility Information Changes form to BAAU@dshs.wa.gov.

BAAU Use Only

ENTERED BY:	DATE ENTERED
<input type="checkbox"/> FMS	
New license required (facility name change)? <input type="checkbox"/> Yes <input type="checkbox"/> No	DATE LICENSE MAILED
Contracts notified of changes (facility name or address)? <input type="checkbox"/> Yes <input type="checkbox"/> No	DATE CONTRACTS NOTIFIED
<input type="checkbox"/> Not processed; returned to Licensee .	DATE RETURNED TO LICENSEE