Washington State Department of Social & Health Services
Transforming lives

Supported Living Information Changes

PROVIDER NAME
CERTIFICATION NUMBER
COUNTY

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

PROVIDER NAME			
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 BAAU@dshs.wa.gov.

BAAU 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**.