Washington State Department of Social & Health Services
Transforming lives

Adult Family Home 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)	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

Did Entity Representative change? ☐ Yes ☐ No   If yes, all information below is required.

☐ New Entity Representative meets qualifications in Chapter 388-76 WAC.

OUTGOING ENTITY REPRESENTATIVE NAME			END DATE
INCOMING ENTITY REPRESENTATIVE 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:	DATE ENTERED
☐ FMS	

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