



Nursing Home Information Changes

FACILITY NAME	
LICENSE NUMBER	CMS FEDERAL 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 Administrator change? Yes No **If yes, all information below is required.**

<input type="checkbox"/> New Administrator meets qualifications in Chapter 388-97 WAC.			
OUTGOING ADMINISTRATOR NAME	END DATE	LICENSE NUMBER	LICENSE EXPIRATION DATE
INCOMING ADMINISTRATOR NAME	START DATE	LICENSE NUMBER	LICENSE EXPIRATION DATE
SOCIAL SECURITY NO.	DATE OF BIRTH		

Did DNS change? Yes No **If yes, all information below is required.**

<input type="checkbox"/> New DNS meets qualifications in Chapter 388-97 WAC.			
OUTGOING DNS NAME	END DATE	LICENSE NUMBER	LICENSE EXPIRATION DATE
INCOMING DNS NAME	START DATE	LICENSE NUMBER	LICENSE EXPIRATION 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
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Please email completed form to BAAU@dshs.wa.gov.

BAAU Use Only

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

ASPEN Use Only

ENTERED BY:	DATE ENTERED
<input type="checkbox"/> ASPEN	