Attachment C

Washington State Department of Social & Health Services
Transforming lives

CONFIDENTIAL INFORMATION – DO NOT DISCLOSE
NOT FOR PUBLIC DISCLOSURE

Assisted Living Facility
Resident List

Not required if facility uses its own list or Attachment D.

ASSISTED LIVING FACILITY NAME	LICENSE NUMBER

INSPECTION DATE	LICENSOR NAME

Inspection Type: ☐ Initial ☐ Full ☐ Follow up ☐ Monitoring ☐ Complaint: Number _____

ROOM NUMBER	RESIDENT NAME	NOTES