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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | | **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 COPY OF WASHINGTON (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 Entity Information change?  Yes  No If yes, complete applicable change(s) below.** | | | | | | | | | | | |
| NEW LEGAL ENTITY NAME (ATTACH COPY OF WA BUSINESS LICENSE AND INTERNAL REVENUE SERVICE EIN VERIFICATION DOCUMENTATION) | | | | | | | | | | | |
| MAILING ADDRESS CITY STATE ZIP CODE | | | | | | | | | | | |
| PHONE NUMBER (WITH AREA CODE) | | | | FAX NUMBER (WITH AREA CODE) | | | | | CELL PHONE NUMBER (WITH AREA CODE) | | |
| **Did Specialty Designations change?  Yes  No If yes, complete applicable change(s) below.** | | | | | | | | | | | |
| CHANGE  ADDED ENDED ER / RM  Dementia  Mental Health  Developmental Disabilities | | | | | | | | | | | |
| **Did Resident Manager change?  Yes  No If yes, all information in this section 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 in this section 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** [**RCSBOA@dshs.wa.gov**](mailto:RCSBOA@dshs.wa.gov)**.** | | | | | | | | | | | |
| **BOA Use Only** | | | | | | | | | | | |
| FMS | CURRENT ER  Yes  No | | ENTERED BY: | | | | | | | | DATE ENTERED |
| DATE LICENSE MAILED  New license required (street address or specialties updated)?  Yes  No | | | | | | | | | | | |
| DATE CONTRACTS NOTIFIED  Contracts notified of changes (facility name or address)?  Yes  No | | | | | | | | | | | |
| DATE RETURNED TO LICENSEE  Not processed; returned to **Licensee**. | | | | | | | | | | | |