|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **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 COPY OF WASHINGTON (WA) BUSINESS LICENSING SHOWING REGISTERED TRADE NAME) | | | | | | | | | | |
| MAILING ADDRESS CITY STATE ZIP CODE | | | | | | | | | | |
| FACILITY NUMBER (WITH AREA CODE) | | 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 Administrator change?  Yes  No If yes, all information below is required.** | | | | | | | | | | |
| 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.** | | | | | | | | | | |
| 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 | | | | | | |
| **Please email completed form to** [**RCSBOA@dshs.wa.gov**](mailto:RCSBOA@dshs.wa.gov)**.** | | | | | | | | | | |
| **BOA Use Only** | | | | | | | | | | |
| ENTERED BY: DATE ENTERED  FMS | | | | | | | | | | |
| DATE LICENSE MAILED  New license required (facility name change)?  Yes  No | | | | | | | | | | |
| DATE CONTRACTS NOTIFIED  Contracts notified of changes (facility name or address)?  Yes  No | | | | | | | | | | |
| DATE RETURNED TO LICENSEE  Not processed; returned to **Licensee**. | | | | | | | | | | |
| **ASPEN Use Only** | | | | | | | | | | |
| ENTERED BY: DATE ENTERED  ASPEN | | | | | | | | | | |