



## Enhanced Services Facility 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)		
EMAIL ADDRESS	WEBSITE		

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

<input type="checkbox"/> New Administrator meets qualifications in Chapter 388-107 WAC.			
OUTGOING ADMINISTRATOR NAME	END DATE		
INCOMING ADMINISTRATOR NAME	SOCIAL SECURITY NO.	DATE OF BIRTH	START DATE

**Signature of Licensee**

**Form submitted without signature will not be processed.**

<b>I attest that all above changes are true and accurate. Forms without a signature will be rejected.</b>	SIGNATURE OF LICENSEE	DATE
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Please email completed form to [RCSBOA@dshs.wa.gov](mailto:RCSBOA@dshs.wa.gov).

**BOA Use Only**

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