

Application for Transition from Group Home to Group Training Home

Section 1. Requirements

This application is to be used when a currently licensed and certified Group Home wishes to transition to a Group Training Home.

Complete this application only if the following answers are yes:

YES NO

- Applicant is currently certified as a Group Home.
- Applicant has a current community residential services contract with Developmental Disabilities Administration (DDA)
- Applicant has a license as an Adult Family Home (AFH) or Assisted Living Facility (ALF).
- The Group Home currently has no unpaid civil fines, stop placement, or provisional certification.

Verify the following information is accurate:

YES NO

- Applicant has not changed its UBI or EIN.
- No partner, officer, director or majority owner of applying entity has changed.
- Applicant is not expanding program into another area of the state.
- Applicant has the same administrator.
- Applicant is not changing its name.

Submitting Application

Submit your application:

For US Postal Mail:

AL TSA BAAU
PO BOX 45600
OLYMPIA WA 98504-5600

For Federal Express:

AL TSA BAAU
4450 10TH AVE SE (BLAKE WEST)
LACEY WA 98503

If you have questions about completing the application, please email the Business Analysis and Applications Unit (BAAU) at BAAU@dshs.wa.gov or call 360-725-2573, we will respond within 48 hours.

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Section 2. Information about the Service Provider			
1. NAME OF SERVICE PROVIDER (DOING BUSINESS AS)	2. LICENSE NUMBER	3. CERTIFICATION NUMBER	
4. BUSINESS STREET ADDRESS	CITY	STATE	ZIP CODE
5. MAILING ADDRESS (IF DIFFERENT FROM ABOVE)	CITY	STATE	ZIP CODE
6. TELEPHONE NUMBER	7. CONFIDENTIAL FAX NUMBER	8. CELL PHONE NUMBER	
7. EMAIL ADDRESS	8. WEB SITE URL(enter NA if no Website)		
Section 3. Legal Entity Information			
1. LEGAL NAME OF ENTITY			
2. UBI NUMBER - -	3. EIN NUMBER -		
Section 4. Notification of Change			
<p>I am requesting that my Group Home be transitioned to a Group Training Home. I am aware that I must relinquish my license as an ALF provider per WAC 388-78A-2783 or as an AFH provider under WAC 388-76-10050.</p> <p>I am aware that I must notify clients and legal representatives 30 days prior to the relinquishment of my license if this request is approved. (per WAC 388-78A-2710 for ALF or WAC 388-76-10210 for AFH) and will provide evidence of notification sent to clients and guardians.</p>			
Section 5. Consent to Release and/or Use Confidential Information			
<p>I consent to the release and use of confidential information about me within the Department of Social and Health Services (DSHS) for purposes of certification. I grant permission to DSHS and any agency, division, office, or the police to use my confidential information and disclose it to each other for these purposes. Information may be shared verbally or by computer, mail, or hand delivery.</p> <p>I am aware that the department is required to respond to requests for disclosure of information from the public. The department may only withhold information if a specific disclosure exemption exists. (RCW 42.56, Chapter 388-101 WAC and Chapter 388-101D WAC).</p> <p>Completion of this form allows the use and sharing of confidential information within DSHS and with the individual applicant / agency for application processing purposes. DSHS may disclose and receive confidential information from outside agencies, divisions, offices and/or the police.</p> <p>This consent is valid for as long as I am the person named in this application. A copy of this form is valid for my permission to release and use this information.</p>			
Section 6. Applicant Certification			
<p>I certify, under the penalty of perjury under the laws of the State of Washington and by my signature, that the information provided in this application and all additional documents and forms required for Certified Community Residential Services and Support Agency are true, complete, and accurate. I understand that the department may obtain additional information, verification and/or documentation related to my answers or information.</p> <p>I understand and agree that the information I give to the department will be used to verify the information in this application. Any information I give to the department may be used by the department for this purpose.</p>			
SIGNATURE OF APPLICANT	DATE	PRINT NAME	