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|  | **Adult Family HomeInformation 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 / RMDementia [ ]  [ ]  [ ] 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****.**  |
| **BOA Use Only** |
| [ ]  FMS | CURRENT ER[ ]  Yes [ ]  No | ENTERED BY: | DATE ENTERED |
|  DATE LICENSE MAILEDNew license required (street address or specialties updated)? [ ]  Yes [ ]  No  |
|  DATE CONTRACTS NOTIFIEDContracts notified of changes (facility name or address)? [ ]  Yes [ ]  No  |
|  DATE RETURNED TO LICENSEE[ ]  Not processed; returned to **Licensee**.  |