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| --- | --- | --- |
|  | **Supported LivingInformation Changes** | PROVIDER NAME |
| CERTIFICATION NUMBER |
| COUNTY |
| **Did Provider Information change? [ ]  Yes [ ]  No If yes, complete applicable change(s) below.** |
| NEW PROVIDER NAME (ATTACH COPY OF WASHINGTON (WA) BUSINESS LICENSE SHOWING REGISTERED TRADE NAME AND INTERNAL REVENUE SERVICE EIN VERIFICATION DOCUMENTATION)  |
| MAILING ADDRESS CITY STATE ZIP CODE |
| STREET ADDRESS CITY STATE ZIP CODE |
| PROVIDER NUMBER (WITH AREA CODE) | CONFIDENTIAL FAX NUMBER (WITH AREA CODE) | CELL PHONE NUMBER (WITH AREA CODE) |
| EMAIL ADDRESS | WEBSITE |
| **Did Administrator change? [ ]  Yes [ ]  No If yes, all information below is required.** |
| **Please attach a letter from Service Provider authorizing change of Administrator.**[ ]  New Administrator meets qualifications in Chapter 388-101D WAC. |
| OUTGOING ADMINISTRATOR NAME (LAST, FIRST, MIDDLE) | END DATE |
| INCOMING ADMINISTRATOR NAME (LAST, FIRST, MIDDLE) | START DATE |
| SOCIAL SECURITY NO. | DATE OF BIRTH |
| **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****.** |
| **BOA Use Only** |
|  ENTERED BY: DATE ENTERED[ ]  FMS  |
|  DATE FORM EMAILED[ ]  Change form e-mailed to SL FM  |
|  DATE RETURNED TO LICENSEE[ ]  Not processed; returned to **Service Provider**.  |