

Office of Investigation and Inspection

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**Request for Health Survey Report**

**of Group Care Facilities**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **A. Facility Name** | | | | **Facility Address** | | | | | | | | | | |
| **City** | | | | **Zip** | | | | | **County** | | | | **Facility Telephone** | |
| **Mailing Address** | | | | | | | | | **City** | | | **Zip** | | |
| **Contact Person(s) and Title** | | | | | | | | | **Contact Person’s Telephone** | | | | | |
| **Previous Name(s) of this center** | | | | | | | | | | | | | | |
| **Previous Address** | | | | | | | | | | | | | |
| **Name(s) of other licensed facilities previously at this location** | | | | | | | | | | | | | |
| **Directions to Facility:** | | | | | | | | | | | | | | |
| **B.**  **Request for Certification as:** Group Care Facility (WAC 388-145) | | | | | | | | | | | | | | |
| Crisis Residential Centers  Day Treatment Programs  Emergency Respite Centers  Group Homes  Group Receiving Centers  Medically Fragile Children | | Overnight Youth Shelters  Maternity Services  Staffed Residential  Homes | | | | | Resource and Assessment  Centers | | | | | | | |  | |
| **C.** **Type of Certification Service Requested:**  Initial  Renewal  Complaint  Increased Capacity   Change of Environment/Use (specify in comments)  Relocation  Change of Ownership (CHOW)  Consultation   Follow-up  Licenser’s Referral | | | | | | | | | | | | | | |
| **D**. **Capacity:**  Current Certified Capacity:  Requested Number of Children:  Ages       Years Through      Years Number of Infants | | | | | | | | License Expiration Date: | | | | | | |
| **E.** **Notification of Facility Status Change:**  Facility closed as of (date)  Facility has withdrawn application as of (date) | | | | | Ownership of facility changed on (date)  Effective Date of Relocation | | | | | | | | | |
| **F. Licenser’s Name** | | | **Licenser’s Email** | | | **Region** | | | | **Mail Stop** | **Telephone** | | | **Date Requested** |
| **Licenser’s Comments:** | | | | | | | | | | | | | |