

 Office of Investigation and Inspection

 P.O. Box 47874

 Olympia, Washington 98504-7874

 E-mail: jon.kuykendall@doh.wa.gov

 Contact Phone: 360-236-2938

 Fax: 360-586-0123

**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| **E.** **Notification of Facility Status Change:****[ ]**  Facility closed as of (date) **[ ]**  Facility has withdrawn application as of (date)  |  **[ ]**  Ownership of facility changed on (date)  **[ ]**  Effective Date of Relocation  |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:**       |