



**MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
DIVISION OF REGULATION AND LICENSURE
SECTION FOR LONG-TERM CARE REGULATION**

CHANGE OF ADMINISTRATOR/MANAGER IN A LONG-TERM CARE FACILITY

FACILITY INFORMATION		
Name of Facility		
Facility Address	City	Zip
Skilled Nursing Facility <input type="checkbox"/> Intermediate Care Facility <input type="checkbox"/> Assisted Living Facility** <input type="checkbox"/> Assisted Living Facility <input type="checkbox"/> Residential Care Facility* <input type="checkbox"/> Residential Care Facility <input type="checkbox"/>		
ADMINISTRATOR INFORMATION		
Name of the person in general administrative charge of the facility:		Effective Date of Change:
If the person is licensed as a Missouri Nursing Home Administrator, indicate the current license number:		
<i>Please provide contact information other than the Long-Term Care Facility Telephone Number:</i>		
Telephone Number	E-Mail Address	
Cell Phone Number	Other Emergency Number	
Does the person in general administrative charge of the facility currently serve other facilities as administrator? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, list facility name, city, and number of beds of all other facilities:</i>		
<i>Facility Name</i>	<i>City</i>	<i># of Beds</i>
Is the person in general administrative charge of the facility currently employed in another position? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, list of the other positions held:</i>		
Previous Administrator's Name:		
Last Date of Employment:		
AFFIDAVIT		
I attest by my signature that the statements contained in this form are true and correct to the best of my knowledge and belief. I further affirm that I have the express authority to sign this form on behalf of the operator.		
Authorized Signature	Date	
Printed or Typed Name	Title of Signatory	
PLEASE RETURN THIS COMPLETED FORM BY MAIL, FAX OR E-MAIL: DEPARTMENT OF HEALTH AND SENIOR SERVICES SECTION FOR LONG-TERM CARE REGULATION LICENSURE UNIT 920 WILDWOOD DRIVE P.O. BOX 570 JEFFERSON CITY, MO 65102 FAX # (573) 751-8493 E-MAIL ADDRESS: LTCAPPLICATION@HEALTH.MO.GOV		
<small>**Licensed as an assisted living facility (ALF) and chooses to accept or retain individuals with a physical, cognitive or other condition that prevents them from safely evacuating the facility with minimal assistance. *Licensed as a residential care facility II on August 27, 2006 and chooses to continue to meet all laws, rules and regulations that were in place on August 27, 2006 for a residential care facility II.</small>		