MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
DIVISION OF REGULATION AND LICENSURE
SUPPLEMENTAL HEALTH CARE SERVICES AGENCY

CHANGES TO A REGISTERED AGENCY FORM

Only fill out sections related to the necessary agency changes.

AGENCY REGISTRATION NUMBER			
CURRENT REGISTERED AGENCY NAME			
NEW REGISTERED AGENCY NAME (IF CHANGING NAME)			
CURRENT REGISTERED BUSINESS PHYSICAL ADDRESS	CITY	STATE	ZIP CODE
NEW BUSINESS PHYSICAL ADDRESS (IF CHANGING ADDRESS) *ADDITIONAL DOCUMENTATION AND INFORMATION MAY BE REQUIRED	CITY	STATE	ZIP CODE
CURRENT REGISTERED BUSINESS MAILING ADDRESS ☐ SAME AS PHYSICAL ADDRESS	CITY	STATE	ZIP CODE
NEW BUSINESS MAILING ADDRESS (IF CHANGING ADDRESS) ☐ SAME AS PHYSICAL ADDRESS	CITY	STATE	ZIP CODE
NEW AGENCY TELEPHONE NUMBER (IF CHANGING NUMBER)	NEW AGENCY FAX NUMBER (IF CHANGING FAX NUMBER)		
NEW OR ADDITIONAL AGENCY EMAIL ADDRESS (IF CHANGING OR ADDING AN EMAIL ADDRESS. ALSO, INDICATE IF A CURRENT EMAIL ADDRESS SHOULD BE REMOVED)			
NEW RESPONSIBLE CONTACT PERSON (IF CHANGING CONTACT PERSON)	NEW RESPONSIBLE CONTACT PERSON EMAIL AND PHONE NUMBER (IF DIFFERENT FROM REGISTERED AGENCY)		
REASON FOR CHANGES LISTED ABOVE:			
RESPONSIBLE CONTACT PERSON NAME			
SIGNATURE	DATE		