Date

Name

Executive Director

Provider Agency Name

Provider Address

City, State Zip

Dear Executive Director:

Your request for a name change from Provider Agency Name to Provider Agency Name located at Provider Address in City has been approved. Your updated revised TOAs are enclosed. These letters must be posted in your facility at all times and are not transferable to any other location or entity.

Please return the TOAs for Provider Agency Name to the Office of Certification Administration within ten (**10**) days of receipt of this letter. Should you have any questions please contact the Office of Certification Administration at 334-353-XXX.

 Sincerely,

 Commissioner’s Full Name

 Commissioner

 (Commissioner’s initials/OCA staff)

 Enclosure

cc: (Service Division Associate Commissioner)

 (Copied Contact)