HOME HEALTH SERVICES
CHANGE OF OWNERSHIP PROCEDURES

1. Submit a notarized application along with the appropriate fee and a letter of intent to the address at the top of the application. The letter of intent should include the name of the facility, the name of the seller of the facility, acknowledgment by the seller authorizing the sale of the facility’s operations and the projected date of the Change of Ownership (CHOW). Submission of a CHOW application indicates the acquisition and sale of the entire facility operations including the associated license.

2. A letter will be sent acknowledging the receipt of the application and fee. Once the change of ownership has occurred and you receive the closing documents, you will need to send a copy of the bill of sale or the documents that indicate that you are now the owner of the facility to:

   Office of Health Care Facilities
   665 Mainstream Drive, Second Floor
   Nashville, Tennessee  37243

3. This office will notify the regional office in your area to request their recommendation for the intended CHOW. The regional office will review the facility file to determine if a survey has been conducted within the previous thirty-six (36) months with no outstanding deficiencies, to determine survey performance history including both scheduled and complaint surveys, and for the approval and completion of all required CMS paperwork i.e.; 855, etc. If a survey has been conducted in the last thirty-six (36) months and the facility’s survey history including complaint surveys is satisfactory, and all required CMS paperwork is approved and present in the regional office, a form recommending approval of the CHOW will be submitted to the central office in Nashville. If a survey has not been conducted within the previous thirty-six (36) months, an on-site survey of the facility will be conducted. The regional office will not recommend approval of the CHOW until an on-site survey is conducted with substantial compliance unless the facility holds accreditation from a federally recognized accrediting body. Deficiencies from either this on-site survey or a previous survey must be corrected before the regional office will recommend approval of the CHOW.

4. Once the recommendation and the signed closing document(s) with the effective date of the CHOW are received in the central office, a letter will be forwarded to you initially approving the CHOW. The effective date of the CHOW will be the date of the closing document(s) is signed or the date the regional office recommends approval of the CHOW, if occurring after the closing date. The application will then be presented to the Board for Licensing Health Care Facilities at the next regularly scheduled board meeting for ratification. If the Board ratifies the approval of the CHOW the license number listed above will become your permanent license number and a letter will be forwarded to you within three working days notifying you of the Board’s final decision. You should receive your wall license within seven (7) to ten (10) days thereafter.

5. If the Board does not ratify the initial approval of the CHOW, that initial authorization shall cease to be effective. A letter will be mailed to you providing an explanation and specific instructions as to any actions you may take to have the decision reviewed.

All applicable laws, rules, policies, and guidelines affecting your practice are available for viewing at http://tn.gov/health/topic/hcf-professionals. Please check this website periodically for updates.
 HOME HEALTH SERVICES
APPLICATION FOR CHANGE OF OWNERSHIP

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Name of the Facility/Agency _____________________________________________________________

Location of the Facility:
Street __________________________________ City ____________________________
County _____________________________ State ____________________________ Zip ______________________
Phone Number (____) __________________ Fax Number (____) __________________
Twenty-four (24) Hour Emergency Phone Number (____) __________________________
E-Mail Address ____________________________

Administrator Information:
Administrator _____________________________________________________________

Have you (Administrator) ever been convicted of a crime involving injury or harm to person(s), financial or business management (e.g., assault, battery, robbery, embezzlement or fraud)?  Yes _____  No _____
If yes, what charge(s)? __________________________________________________________
Location of Conviction __________________________________________________________
(City) ____________________________ (County) ____________________________ (State) __________________

Mailing address if different from the Facility location address:
Name _____________________________________________________________
Street _____________________________________________________________
City ____________________________ State ____________________________ Zip ______________________

Ownership of Building:
Name __________________________________ Phone Number (____) __________________________
Street _____________________________________________________________
City ____________________________ State ____________________________ Zip ______________________

FEE SCHEDULE: (FEES ARE NON-REFUNDABLE) $1,080
1. Check type: Hospital Based ______ Nursing Home Based ______ Free Standing ______

2. Check type: Licensed only Agency ______ Licensed/Medicaid Certified ______

3. Geographic area served by Agency: (list county or counties) If additional space is needed, please use a separate page.

4. Check type of services provided:
   a. Skilled Nursing ______
   b. Physical Therapy ______
   c. Occupational Therapy ______
   d. Speech Therapy ______
   e. Medical Social Services ______
   f. Home Health Aid Services ______
   g. Medical Supplies and Appliances ______
   h. Homemaker Services ______
   i. Other (please specify) ______

5. Number of branch offices: ________
   Address of each branch office: (If additional space is needed, please use a separate page)

6. OWNERSHIP OF BUSINESS:
   a. Check the type of Legal Entity:
      _____ Individual _____ Partnership _____ Corporation _____ Limited Liability Company
      _____ Church Related _____ Government/County _____ Other
   b. Check one: _____ For Profit _____ Non-profit
   c. Legal Entity checked in 1.a:
      Name ___________________________ Phone Number (____) ___________________________
      Address ___________________________
   d. List name(s) and address(es) of individual owners, partners, directors of the corporation, or head of the governmental entity:
      Name ___________________________ Street ___________________________ City, State, Zip ___________________________
      Name ___________________________ Street ___________________________ City, State, Zip ___________________________
      Name ___________________________ Street ___________________________ City, State, Zip ___________________________
      (If additional space is needed, please use a separate sheet)

2. a. Is your facility/organization accredited by a federally approved accrediting body (i.e., JCAHO, CARF, etc)?
    Yes _____ No _____ Expiration Date ___________________________
   b. Is your facility/organization deemed by a federally approved accrediting body? (i.e., JCAHO, CARF, etc)?
    Yes _____ No _____ Expiration Date ___________________________
3. If you have a parent company please provide the following information:
   Name ___________________________________ Phone Number (_____) ____________________
   Address ________________________________________________________________

4. a. Are any owners of the disclosing entity also owners of other health care facilities in Tennessee and/or other states?  Yes _____ No _____
   b. If yes, list names and addresses of all such facilities:

   ________________________________________________________________

5. a. Do you have a contract with a management firm to operate this facility?  Yes _____ No _____
   If yes, specify dates: From ________________ To __________________________
   b. If yes, please specify name of firm: _________________________________
   Phone Number (_____.
   Street ___________________________ City, State, Zip ______________________

6. a. Have any owners of the disclosing entity ever been denied a license, had a license suspended or revoke, had a suspension of admissions or paid any civil monitory penalties for a health care facility in Tennessee or in any other state?  Yes _____ No _____
   If yes, where? __________________________________________________________ When? __________
   For what reason? _______________________________________________________

VERIFICATION BY NOTARY PUBLIC:

Signee for application certifies that he or she is of responsible character and able to comply with the minimum standards and regulations established by Tennessee pertaining to the type of facility or agency for which application for licensure is made and with the rules promulgated under Tennessee Code Annotated (TCA) § 68-11-201.

Signee also certifies that a policy has been implemented to inform all employees of their obligation under TCA § 71-6-103 to report incidents of abuse or neglect.

Applicant Signature ____________________________________________ Title or Position ___________ Date ___________

STATE OF TENNESSEE

County of _____________________________

The above named applicant (print name) ______________________________________, being by me duly sworn on his/her oath, deposes and says that he/she has read the forgoing application and knows the contents thereof: that the statements concerning the above named facility or agency, therein contained, are correct and true to his/her own knowledge.

Subscribed to and sworn to on this ___________ day of ____________________ (Month) ____________________ (Year)

Notary Public: ________________________________________________

My commission expires: __________________________________________