LOUISIANA DEPARTMENT OF HEALTH

**Health Standards Section**

# Application & Checklist for ASC DBA Name Changes

**(not to be used to change the Entity/Corporation/Legal Name)**

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|---|---|
| **Application Date:** | **Effective Date:** |
| **ASC "DBA" Name (previous):** | |
| **ASC "DBA" Name (new):** | |
| **ASC Address:** | |
| **ASC Fax:** | |
| **Administrator:** | **Designated Contact Person:** |
| **Administrator Phone:** | **Designated Contact Phone:** |
| **Administrator Email:** | **Designated Contact Email:** |

| **Requirements for ASC dba Name Change**<br>**(Each of these must be attached in order for your application to be processed)**: | **Yes** |
|---|---|
| Application & Checklist for ASC DBA Name Changes (Form HSS-AS-010) | ☐ |
| Letter of Intent | ☐ |
| Licensing fee of $25.00 to reprint the license | ☐ |
| Disclosure of Ownership showing the new DBA name (Form CMS 1513L) | ☐ |
| 855B Approval Letter from fiscal intermediary | ☐ |

*ATTESTATION: I certify that I have reviewed the Ambulatory Surgical Center (ASC) licensing requirements. I certify that the above referenced ASC meets and will continue to meet all applicable requirements for ASCs set forth in the State of Louisiana Rules, Regulations and Minimum Standards (LAC 48:I, Chapter 45), all applicable Conditions of Coverage set forth in the Code of Federal Regulations, and all applicable requirements of the Office of State Fire Marshall and Office of Public Health. I agree that if the ASC fails to meet any of these requirements, I will notify the Health Standards Section of the Louisiana Department of Health of the changes immediately in order to permit a valid determination of the ASC's compliance with the aforementioned regulations and requirements. I understand that if the agency license is granted, it is granted for one year and shall become void upon change of ownership, change of location, or cessation of business. It is my responsibility to notify the Health Standards Section of the Louisianan Department of Health in writing of any changes in the information provided in this application. Documentation of the information above is available upon request by the Louisiana Department of Health and/or the Centers for Medicare and Medicaid Services (CMS). I understand that the Health Standards Section of the Louisiana Department of Health and/or the Centers for Medicare and Medicaid Services (CMS) has the right to conduct an on-site survey at any time to validate whether the information provided is true. I certify that the information herein is true, correct and supportable by documentation to the best of my knowledge.*

***EMERGENCY PREPAREDNESS ATTESTATION:*** *I certify that I am in compliance with all appropriate federal, state, departmental or local statutes, laws, ordinances, rules and regulations concerning emergency preparedness.*

| | |
|---|---|
| Authorized Representative Name (typed or printed): | |
| Authorized Representative Signature: | Date: |

***HSS-AS-10 Rev (2/2010, 9/2014, 2/2020)***

**Health Standards Section**
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