



## Health Standards Section (HSS)

### KEY PERSONNEL CHANGE FORM

<b>Legal Entity Name:</b> _____		
<b>Agency DBA Name:</b> _____		
<b>Provider License #:</b> _____		<b>Provider CMS ID # (if applicable):</b> _____
<b>Address:</b> _____		
<b>City, State, Zip:</b> _____		
<b>Telephone Number:</b> _____		<b>Fax Number:</b> _____
<b>Administrator's Email Address:</b> _____		<b>Proposed Employee's Email Address:</b> _____
<b>Check the position that is changing (please check only those appropriate to the Provider Type):</b> <input type="checkbox"/> <b>Administrator</b> (the person with overall responsibility for the day-to-day administrative operations) <input type="checkbox"/> <b>Director of Nursing</b> (the registered nurse providing leadership of nursing services – if applicable) <input type="checkbox"/> <b>Medical Director</b> (the physician providing oversight of the clinical operations – if applicable) <input type="checkbox"/> <b>Other:</b> _____		
<b>Name of <i>previous</i> employee in this position:</b> _____		
<b>Name of <i>proposed</i> employee for this position:</b> _____		
<b>Effective Date of Change:</b> /     /		
<b>Verification Date of Current Louisiana Professional License:</b> /     / Please enter the date on which the agency verified the current professional licensure of the proposed employee, <i>if licensure is a requirement for the position</i> . The date should precede the effective date of change.		
<b>State Incident Management System (SIMS) Access</b> <i>Intermediate Care Facility for the Developmentally Disabled and Nursing Facilities Only</i>		
The <i>proposed</i> employee needs access to SIMS: <input type="checkbox"/> YES <input type="checkbox"/> NO		
Register/Reactivate/Deactivate for SIMS at <a href="https://www.ldh.la.gov/page/statewide-incident-management-systems-sims">https://www.ldh.la.gov/page/statewide-incident-management-systems-sims</a>		
The <i>proposed</i> employee currently has access associated with another provider: <input type="checkbox"/> YES <input type="checkbox"/> NO		
The <i>previous</i> employee currently has access to SIMS: <input type="checkbox"/> YES <input type="checkbox"/> NO		
<b>ESF-8 Portal (MSTAT) Access</b> <i>Intermediate Care Facility for the Developmentally Disabled, Nursing Facilities, Adult Residential Care Providers, and Hospitals Only</i>		
The <i>proposed</i> employee needs access to the ESF-8 portal: <input type="checkbox"/> YES <input type="checkbox"/> NO		
The <i>proposed</i> employee currently has access to the ESF-8 portal associated with another provider: <input type="checkbox"/> YES <input type="checkbox"/> NO		
The <i>previous</i> employee currently has access to ESF-8 portal: <input type="checkbox"/> YES <input type="checkbox"/> NO		
<b>Attestations of Compliance</b>		
We hereby certify that the proposed employee listed herein meets all state/federal requirements set forth by the Louisiana Department of Health (LDH), HSS; the Centers for Medicare and Medicaid Services; and any other regulatory agency applicable to the Provider Type, to function in the role indicated. We further understand that it is the responsibility of the administrator to ensure that the agency maintains compliance with state/federal regulations on an ongoing basis, and that the LDH, HSS will be promptly notified of any changes to key personnel.		
_____ Printed Name of Proposed Employee	_____ Signature of Proposed Employee	_____ Date (mm/dd/yy)
_____ Printed Name of Proposed Administrator	_____ Signature of Proposed Administrator	_____ Date (mm/dd/yy)
PLEASE NOTE: <i>This form must be signed by the proposed employee and the administrator.</i> This form is used for all HSS licensed providers/suppliers. Definitions of key personnel may be found in the applicable state licensing regulations for the specific Provider Type.		

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