LOUISIANA DEPARTMENT OF HEALTH
Health Standards Section

Ownership Change License Application

Section 1: Licensing Action (Must Be Completed)	
☐ Change of Ownership (CHOW)	☐ Change of Ownership Information (CHOI)
Effective Date of Change:	

Section 2: Type of Facility /Provider (Must Be Completed)		
☐ Abortion Clinic	☐ Adult Brain Injury Facility	☐ Adult Day Health Care (FNR)
☐ Adult Residential Care Provider (FNR– Level 4)	☐ Ambulatory Surgical Center	☐ Behavioral Health Services (FNR)
☐ Community Mental Health Center	☐ Crisis Receiving Center	☐ Comprehensive Outpatient Rehab Facility
☐ End Stage Renal Dialysis Center	☐ Emergency Medical Transportation Service	☐ Forensic Supervised Transitional Aftercare Facility
☐ Home Health Agency	☐ Home & Community Based Provider (FNR)	☐ Hospice (FNR)
☐ Hospital	☐ Intermediate Care Facility (FNR)	☐ Nurse Staffing Agency
☐ Outpatient Rehab Facility	☐ Pain Management Clinic	☐ Nursing Facility/Nursing Home (FNR)
☐ Portable X-Ray Provider	☐ Psych Residential Treatment Facility	☐ Pediatric Day Health Care Facility (FNR)
☐ Support Coordination	☐ Therapeutic Group Home	☐ Rural Health Clinic

Section 3: CURRENT License Information (Must Be Completed)		
Facility/Provider License #:	**License Expiration Date:**	**State ID:**
Facility/Provider Doing Business As:		
Facility/Provider Geographical Address:		

Section 4: Payment Information (Must Be Completed if there is a Fee Associated with this Action)	
Check or Money Order Number:	Check Amount:
Date Payment & Payment Transmittal Form:	Date Emailed Ownership Change License Application:
Mailed to: DHH Licensing Payments P.O. Box 734350 Dallas, TX 75373-4350	HSSOwnerships@la.gov

Section 5: Facility Need Review (Must Be Completed)
Does this Facility/Provider require FNR? ☐ Yes ☐ No If yes, must provide proof of the seller's or transferor's intent to relinquish the FNR approval.

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THE REMAINING INFORMATION SHOULD BE COMPLETED AS APPLICABLE FOR THE NEW BUYER

Section 6: Facility/Provider/Administration (Must Be Completed)

Facility/Provider Doing Business As, IF different from previous:

Facility/Provider Geographical Address, IF different from previous:

Is this change as a result of the CHOW? ☐ No ☐ Yes
If yes, please check with the applicable program desk to determine if additional information and fee are needed.

Does the Facility/Provider have a different mailing address? ☐ No ☐ Yes	**If yes, please provide the mailing address:**
Facility/Provider telephone #:	**Facility/Provider Fax #:**

Is the Facility/Provider co-located on the campus or in the building of another Facility/Provider? ☐ No ☐ Yes
If yes, list the name of the Host Facility/Provider:

Parish of Facility/Provider:	**Fiscal Intermediary (if applicable):**	**Fiscal Year End Date (Month/Year):**
Accrediting Organization (if applicable):		**Accreditation Exp:**

Administrator - Is this a change? If yes, submit a Key Personnel Change Form to the program desk.	**Director of Nursing - Is this a change?** If yes, submit a Key Personnel Change Form to the program desk.
Name:	**Name:**
Phone:	**Phone:**
Email:	**Email:**
Designated Contact Person (if different from above)- Name:	
Telephone:	**Email:**

Section 7: Type of Ownership (Must Be Completed)

Non-Profit (Must submit evidence of Non-profit status)	**For Profit**	**Government** (Must submit evidence of Governmental status)
☐ Individual/Sole Proprietor	☐ Individual/Sole Proprietor	☐ Federal Facility
☐ Corporation	☐ Corporation	☐ Service District
☐ Limited Liability Company	☐ Limited Liability Company	☐ State Facility
☐ Partnership	☐ Partnership	☐ Combination Gov-N-Profit
☐ Religious Affiliation	☐ Group Practice	☐ Parish (specify):
☐ Unincorporated Association	☐ Other:	☐ Other:
☐ Other:		

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Section 8: New Owner Information (Must Be Completed)	
Legal Entity/Facility/Provider Name:	**EIN:**
Legal Entity/Facility/Provider Mailing Address: **Legal Entity/Facility/Provider City/State/Zip:**	
Legal Entity/Facility/Provider Phone #:	**Legal Entity/Facility/Provider Fax #:**
Legal Entity/Facility/Provider Email:	

Section 9: Ownership (Must Be Completed)

List name, address, and telephone numbers for persons or groups of persons, or the employer identification number (EIN) for organizations having direct or indirect ownership or a controlling interest (5% or more) of the corporate stock or partnership interest or any person or business entity which has a direct business interest, including, but not limited to, a wholly owned subsidiary, the details of any conversion rights which may exist for the benefit of any party and whether such stock, partnership interest, or ownership being held by the disclosed person or business entity is, in fact, owned by another person or business entity. (Attach additional sheets if additional space is needed).

Owner Name	Address

Section 10: Corporation Ownership ☐ **(Not applicable)**

If the disclosing entity is a corporation, list name, address, and telephone number of the President

Chief Officer's Name	Chief Officer's Address	Chief Officer's Telephone #

Section 11: Must Be Completed for a CHOW of a Medicare Certified Provider/Facility ☐ **(Not applicable)**

A provider who is contemplating or negotiating a CHOW must notify CMS (42 CFR §489.18(b)). Indicate if the prospective owners will participate in the Medicare program by checking the appropriate sections below:

☐ Prospective owner **does not intend** to participate in the Medicare program.
☐ Prospective owner **intends** to participate in the Medicare program *(choose one)*:
- ☐ Prospective owner **accepts** assignment of the previous owner's provider agreement.
- ☐ Prospective owner to apply for a **new** provider agreement.

Section 12: Branch, Off-Site or Satellite ☐ **(Not applicable)**

To include all sites being billed under the Facility/Provider agreement or any NPI numbers associated with the Facility/Provider

(Please copy this page and use for additional off-site campus information if needed

License #	Branch, Off-Site or Satellite DBA Name & Address	Services	Parish	Phone (Direct line- no voicemail)	Fax
	Offsite name as it will appear on the license: Offsite address:				

Section 13: Emergency Preparedness Attestation & Signature

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's Printed Name & Title:

Authorized Representative's Signature: **Date:**

Section 14: Attestation & Signature

I understand that if the agency license is granted, it is granted for one year and shall become void upon change of ownership or change in geographical address. It is my responsibility to notify the Louisiana Department of Health, Health Standards Section, in writing of any changes in the information provided in this application in a separate packet. I attest that the Facility/Provider currently complies with the applicable requirements of the Office of State Fire Marshal, Office of Public Health and building codes. I certify that the information herein is true, correct and supportable by documentation to the best of my knowledge. Documentation of the information above is available upon request by the Louisiana Department of Health.

Authorized Representative's Printed Name & Title:

Authorized Representative's Signature: **Date:**