Indiana Department of Health
Long Term Care
Change of Ownership Application Title 19 NF

This letter is to inform applicants of the required documentation for a change of ownership application for Medicaid certified health facilities.

A cover letter, that includes a contact name, phone number, email, and address should be submitted with items 1-5 and 7 listed below for the Change of Ownership (CHOW) application **at least 30 days prior to the effective date of the CHOW, however, 45 days is suggested**. Item 6 should be submitted to the Department of Health (Department) within one (1) working day of the effective date. Submission of the application form and supporting documents within the time frames set out above will avoid expiration of the license and/or unnecessary delays in assuming control of an existing facility. Items 1-7 must be received and approved prior to the Department issuing a license. Items 8-15 are due 21 days from the date of the authorization letter. Applications will be reviewed in the order received at the Department.

An application should include a cover letter and the following forms and/or documentation:

1. State Form 8200, Application for License to Operate a Health Facility, with required attachments.
2. State Form 19733, Implementing Indiana Code 16-28-2-6.
3. Documentation of the applicant entity's registration with the Indiana Secretary of State with d/b/a if applicable.
4. State Form 51996, Independent Verification of Assets and Liabilities, to include required attachments.
5. Licensure Fee, payable by check or money order to the Indiana Department of Health, in the amount of two hundred dollars ($200.00) for the first fifty (50) beds; ten dollars ($10.00) for each additional bed.
6. **Fully executed copy(ies)** of the Bill of Sale, Lease, Asset Purchase Agreement, or other legal documents for the change of ownership, which indicates the effective date for the change of ownership transaction. The documents provided must establish a clear and unbroken chain between the current licensee and the CHOW applicant.
7. Internal Revenue Services (IRS) documentation – Submit a document from the IRS that reflects the legal entity's name and EIN. The document must be **from the IRS sent to the provider** not a form/document the provider completed and sent to the IRS.
8. One (1) signed original of form CMS-671, Long Term Care Facility Application for Medicare and Medicaid https://www.cms.gov/medicare/cms-forms/cms-forms/cms-forms-items/cms006581
9. Documentation of compliance with Civil Rights should be filed online at https://ocrportal.hhs.gov/ocr/aoc/instruction.jsf
    - A copy of the online confirmation **from** OCR showing the provider has completed the civil rights submission online should be submitted to ISDH;
10. Completed State Form 4332, Bed Inventory.

11. Facility floor plan on 8 ½" x 11" paper with room numbers;
12. Copy(s) of the Patient Transfer Agreement between the facility and local hospital(s);
13. SF 55283, Contract and Service Agreement Checklist and copy(s) of new Services Agreements/Contracts between the applicant entity and third parties.
14. SF 55282, Proposed Staffing Structure.
15. Copy of the facility's disaster plan.

The facility must contact the State Medicaid Agency Contractor to obtain a Provider Enrollment Agreement for Medicaid participation. This should be submitted directly back to them for processing.

The following is a general outline of the application process:

1. Upon receipt of the above items 1-7, and upon the Division Director's satisfaction that the applicant entity meets the requirements of Indiana Code 16-28-2-1 et seq., the Director may grant authorization for the applicant entity to operate the facility;
2. If the authorization is granted, the remainder of the application items are due **no later** than twenty-one (21) days from the date of the authorization to operate letter;
3. Upon receipt of the completed change of ownership application documentation, the Division of Long Term Care will forward appropriate document(s) to the State Medicaid Agency for processing;
4. The State Medicaid Agency will forward to the facility a letter acknowledging the change of ownership.

Under normal circumstances, a licensure and certification survey for a change of ownership is not required.

Please mail completed application packets to the following address:

Long Term Care – Provider Services
Indiana Department of Health
2 N. Meridian St., Section 4-B
Indianapolis, IN 46204

Email questions regarding the application process to ltcproviderservices@isdh.IN.gov.