



STATE OF TENNESSEE  
DEPARTMENT OF HEALTH  
DIVISION OF HEALTH LICENSURE AND REGULATION  
OFFICE OF HEALTH CARE FACILITIES  
665 MAINSTREAM DRIVE, SECOND FLOOR  
NASHVILLE, TENNESSEE 37243  
(615) 741-7221

PROFESSIONAL SUPPORT SERVICES  
CHANGE OF OWNERSHIP PROCEDURES

1. Submit a notarized application along with the appropriate fee, a letter of intent and a copy of the initial approval letter from the Department of Intellectual and Developmental Disabilities (DIDD) 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 an annual survey has been conducted within the previous fifteen (15) months with no outstanding deficiencies, to determine survey performance history including both annual and complaint surveys, and for the approval and completion of all required (**IF applicable**) CMS paperwork i.e.; 855, etc. If an annual survey has been conducted in the last fifteen (15) 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 an annual survey has not been conducted within the previous fifteen (15) 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 contingent on you executing a final provider agreement with DIDD/TennCare. 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 **ONLY** after HCF has received a copy of the final executed provider agreement. 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 [www.state.tn.us/health](http://www.state.tn.us/health). Please check this website periodically for updates.*



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NASHVILLE, TENNESSEE 37243-0508  
(615) 741-7221

**PROFESSIONAL SUPPORT SERVICES  
APPLICATION FOR CHANGE OF OWNERSHIP**

All applicable laws, rules, policies, and guidelines affecting your practice are available for viewing at [www.tn.gov/health](http://www.tn.gov/health). Please check this website periodically for updates.

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 \_\_\_\_\_ Date \_\_\_\_\_  
(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)**

\$270 - If one of the following apply, please place check beside the one that applies and submit proof:

- 1. You are currently licensed by the Department of Mental Health and Developmental Disabilities
- 2. You are a therapist who pays a fee to be licensed by Title 63, Chapter 13 or 17 and own a home care organization
- 3. You are a home care organization owned and controlled by another home care organization and pay an annual licensure fee of \$1,080

\$1,080 - If you are a home care organization authorized to provide professional support services only

1. Does your facility have a current provider agreement with DIDD to provide Professional Support Service? **(Please refer to the #4 note on the instruction sheet).** Yes  No

2. Geographic area served by Agency: (check appropriate region or regions).

East  Middle  West

3. Check type of services provided:

- a. Skilled Nursing
- b. Physical Therapy
- c. Occupational Therapy
- d. Speech Therapy

**OWNERSHIP OF BUSINESS:**

1. 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, specify name of firm: \_\_\_\_\_

Phone Number (\_\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_  
Name 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 \_\_\_\_\_

b. If yes, where? \_\_\_\_\_ When? \_\_\_\_\_

c. 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: \_\_\_\_\_