PROFESSIONAL SUPPORT SERVICES
CHANGE OF OWNERSHIP PROCEDURES

1. Submit a notarized application along with the appropriate fee and a letter of intent 60 days prior to the anticipated Change of Ownership (CHOW) and a copy of the initial approval letter from the Department of Intellectual and Developmental Disabilities (DIDD) to the address at the bottom of the application. The letter of intent should include the name of the facility, the name of the seller\lessee of the facility, acknowledgment by the seller\lessee authorizing the sale or lease of the facility's operations and the projected date of the CHOW. Submission of a CHOW application indicates the acquisition and sale\lease of the entire facility operations including the associated license.

2. A letter will be sent acknowledging the receipt of the application, fee and notice of intent. 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, including lease of operations agreements, that indicate that you are now the owner or lessee of the facility to:

   Health Facilities Commission
   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 when the last annual survey was conducted with no outstanding deficiencies, and secondly to determine survey performance history including both scheduled and complaint surveys. If the most current annual survey and the facility's survey history including complaint surveys is satisfactory, a form recommending approval of the CHOW will be submitted to the central office in Nashville. If any complaint(s) rising to the level of a detriment to the health, safety, and welfare of the residents of the facility has been reported then; 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 and/or deficiencies from either this on-site survey or a previous survey are corrected. The applicant/buyer will be notified by the central office if an onsite survey is necessary.

4. Once the recommendation is received in the central office from the regional office, a letter will be forwarded to you initially approving the CHOW pending the completion and submission of the final bill of sale (closing document(s)), and 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 and dated by the seller/ buyer or lessee; 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. 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) business 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 https://www.tn.gov/hfc/division-of-licensure-and-regulation/hfc-licensure/licensure-applications.html.. Please check this website periodically for updates.

PROFESSIONAL SUPPORT SERVICES
APPLICATION FOR CHANGE OF OWNERSHIP

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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)**

$351.00 - 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 $1,404

$1,404 - 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 _____ c. Occupational Therapy _____

b. Physical Therapy_____ d. Speech Therapy _____

SITE CODES:

1. Number of site codes:_____

a. Code number, address and phone number of site codes: **(*If additional space is needed, please use a separate sheet)***

_____

_____

_____

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

(If additional space is needed, please use a separate sheet)

e. If a government/county owned facility, does the administrator have authority to act on behalf of the government/county as it relates to the operation of this facility? Yes _____ No _____

f. If no to e., who has said authority? _____

2. a. In accordance with Rule 0720-35-.02, is this CHOW a lease of operation? Yes_____ No_____

b. If yes, please provide the lessor's information below:

Name_____Phone Number (___)_____

Address_____

3. a. Is your facility/organization accredited by a **federally approved** accrediting body including but not limited to JCAHO, CARF, etc.? **Provide proof of accreditation.**

Yes_____ No_____ Expiration Date_____

4. Is this facility chain affiliated? Yes_____ No_____

5. If you have a parent company, please provide the following information:

Name_____Phone Number (_____)_____

Address _____

6. a. If a corporation, is there a holding company? Yes _____ No _____

b. If yes, list the name, address, and phone number of the holding company:

Name_____Phone Number (_____)_____

Street_____

City_____State_____Zip_____

7. 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: ***(If additional space is needed, please use a separate sheet)***

_____

_____

8. 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

9. For any item in (7) a-h below, please identify, explain and provide documentation of the item(s) noted if response is "Yes". Have either the licensed entity for any of the other health care facilities in Tennessee and/or other states on the list in question (5.b.) above, OR the management firm listed in question (6.) above; been subjected to any of the following within the last (5) years:

a. Licensure

i) denied a license ? Yes____No_____

ii) had a license suspended or revoked by any state licensure agency? Yes____No_____

iii) been subject to a final order or judgment in a state licensure action? Yes____No_____

b. Convictions

i) convicted of a criminal offense related to that person's involvement in any program under any state or Federal health care program (including Medicare, Medicaid, and Tricare)? Yes____No_____

c. Exclusion

i) excluded from participation in Federal health care programs (Medicare, Medicaid, CHIP, or Tricare) in the past? Yes____No_____

(Note: "Excluded" is defined as a provider or entity has been told by the Department of Health and Human Services, Office of the Inspector General (HHS-OIG) that they may no longer be a provider for any federally funded healthcare program).

d. Termination/Suspension

i) suspended or terminated from participation in Medicare or Medicaid/TennCare programs? Yes____No_____

(Note: This would include involuntary termination of a nursing facility or skilled nursing facility by the Centers for Medicare and Medicaid Services (CMS) or state Medicaid agency).

e. Fraud and Abuse

i) paid through settlement, or civil or criminal fines, any monies to the federal government or any state as a result of any administrative or judicial proceeding based on allegations of fraud or abuse involving claims related to the provision of health care items and services? Yes No_____

f. Corporate Integrity Agreement

i) Is presently an entity covered by and subject the terms of a corporate integrity agreement? Yes____No_____

(Note: If yes, provide a copy of CIA)

g. Bankruptcy

i) filed bankruptcy under any provision of the United States Bankruptcy Code? Yes____No_____

h. Civil Monetary Penalty (CMP)

i) paid to the Centers for Medicare and Medicaid Services or any state Medicaid agency a civil money penalty equal to or greater than $250,000.00 as a result of an enforcement action during a survey? Yes____No_____

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.

Signee acknowledges that the State of Tennessee may share information regarding the activities and compliance of the licensee, if the submitted CHOW application is a lessor and/or lessee transaction as described in the above Ownership of Business section of this application.

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: _____