



Office of Health Assurance and Licensing  
**Health Care Facility**  
**Change of Ownership Application Instructions**

**General Information and Instructions**

Section 3702.30 of the Revised Code (RC) and Chapter 3701-83 of the Ohio Administrative Code (OAC) require all health care facilities (HCFs) to be licensed, and also set forth the conditions for licensure. Rules 3701-83-01 through 3701-83-14 pertain to all HCFs; in addition, rules 3701-83-15 through 3701-83-22 pertain specifically to ambulatory surgical facilities (ASFs).

Chapter 3701-83-04(E) of the Ohio Administrative Code states that a health care facility (HCF) shall notify the director, in writing, no later than 30 days of any changes in the information contained in the statement of ownership made in the license application. To apply for a change of ownership, please complete the "Health Care Facility Licensure Application – HEA 1870" making sure to indicate the correct application type (Change of Ownership) in box 1 of the form.

For timely processing, you should submit your completed application form along with the fee and the required documents within 30 days from the effective date of the change of ownership.

**A check or money order, made payable to the Treasurer, State of Ohio in the amount of \$300 must accompany your application.**

**Required Documents**

The following documents must be submitted with your "Health Care Facility Licensure Application" and fee:

1. Change of Operator/Owner Consent Form (HEA 8012)
2. Bill of sale
3. A copy of the Certificate of Occupancy Permit
4. 8 ½" x 11" schematic drawing (floor plan) of the facility that clearly shows the operating rooms and procedure rooms
5. A copy of a current State Fire Marshal Inspection report documenting the facility is in compliance with the state fire code
6. Accreditation award letter, if accredited
7. Transfer Agreement with a local hospital for that specifies an effective procedure for the safe and immediate transfer of patients from the ASF to the hospital when care beyond the care that can be provided at the ASF is necessary, including when emergency situations occur or medical complication arise. This agreement must be updated every two years. *If the ASF is a provider based entity of a hospital, a transfer agreement is not needed, and the ASF may submit a letter on facility letter stating that the ASF is a provider based entity of a hospital in place of a transfer agreement.*

**Application Submission**

Submit the completed application form, check or money order in the correct amount, and the required documents listed above to the following address:

Ohio Department of Health  
Revenue Processing #3500  
PO Box 15278  
Columbus, Ohio 43215

If the application is incomplete or is not accompanied with the fee and required documents listed above, licensure approval may be delayed, your application may be returned to you or your application may be denied. Deposit of your fee does not mean that your application has been accepted and/or declared complete.

**Contact Information**

If you have any questions regarding your ambulatory surgical facility licensure application, please e-mail the Bureau of Regulatory Operations in the Office of Health Assurance and Licensing, Ohio Department of Health at [liccert@odh.ohio.gov](mailto:liccert@odh.ohio.gov) or call (614) 466-7713.

# Health Care Facility Licensure Application

As defined in section 3702.30 of the ORC and 3701-83-04 of the OAC

<b>ODH Use Only</b> ID #  OHL #
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Print Legibly in Ink or Type

1. Application Type  <input type="checkbox"/> Initial <input type="checkbox"/> Change of Ownership <input type="checkbox"/> Initial/Replacing existing facility, ID#	2. Date of operation or projected opening date or date of change of ownership.
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3. Licensure Type  only one

<input type="checkbox"/> <b>Ambulatory surgical facility</b>  # of operating rooms  # of procedure rooms  Is this facility located in a building that houses in-patient care? <input type="checkbox"/> No <input type="checkbox"/> Yes  <input type="checkbox"/> <b>Freestanding inpatient rehabilitation facility</b>  # of patient care beds	<input type="checkbox"/> <b>Freestanding dialysis center</b>  # of hemodialysis stations  # of peritoneal stations  # of training stations   <input type="checkbox"/> <b>Freestanding birthing center</b>  # of birthing rooms
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4. Facility name (DBA)	Telephone number	
6. Previous facility name, if applicable		
7. Address		
City	Zip	County
8. E-mail address		

9. Mailing address, if different from above

Name		
Address		
City	State	Zip

10. Days and hours of operation for this facility

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
A.M.							
P.M.							

11. Is this health care facility accredited or certified? <input type="checkbox"/> No <input type="checkbox"/> Yes
If yes, type
If yes, enclose a copy the current accreditation inspection report with this application.

12. This business is a/an <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Limited Liability Company <input type="checkbox"/> Corporation <input type="checkbox"/> Association <input type="checkbox"/> Other:
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**Individual owner:** Skip questions 19 through 29 **only**.

More than one owner, partnership, corporation, limited liability company or association, skip questions 13 through 18 **only**.

13. Owner's name		
14. Address		
City	State	Zip
15. Phone number	16. Owner's occupation	

17. Owner's business address, if different from question #7

Address			
City	State	Zip	18. Phone number

**Multiple Owners, Partnership, Limited Liability Company, Corporation, Association, Other**

19. Business entity name (Legal name as registered with the Secretary of State)			
20. Address			
City	State	Zip	21. Phone number
22. Business Activity			
23. This business is a <input type="checkbox"/> For profit <input type="checkbox"/> Not for Profit <input type="checkbox"/> Government	24. Date of incorporated or registration		25. Charter/registration number

26. List the **name of each person** who has an ownership interest of 5% or more in the business (attach additional sheets if necessary).

Name	Name
Name	Name
Name	Name

27. Officers names, titles, addresses and phone numbers

Title	Name	Address	Phone Number

28. Statutory agent's name (As Registered with the Secretary of State)	Address	Phone Number

29. If state agency or local government, the name, address and phone number of individual authorized to enter into agreement on behalf of state agency or local government.  **Not Applicable**

Name	Address	Phone Number

30. On-site administrator's name	
31. Medical director's name or individual responsible for the provision of health care services	32. License/Certification #

33. Has the new owner(s), administrator or medical director been affiliated through ownership or employment with any of the facilities listed in rule 3701-83-04(A)(1)(c) of the OAC within five years prior to the date of this application?  
 No  Yes *If "yes", provide in writing the individual's name(s) and address(es) of the facilities.*

34. Has the owner(s), administrator or medical director been convicted of any criminal conviction, civil judgment or administrative adjudication related to the provision of care or bearing a direct or substantial relationship to the job responsibilities he/she is to carry out?  
 No  Yes *If "yes", provide in writing the individual's name, full explanation stating the charge(s), date(s) and disposition(s).*

I affirm that to the best of my knowledge and belief, the answers provided herein and all accompanying materials are true and correct. I understand that section 3702.30 of the Ohio Revised Code and paragraph (E) of rule 3701-83-04 of the Ohio Administrative Code require the owner to inform the Director, in writing, of any changes in the information contained in the statement of ownership set forth in the initial application and any change in accreditation status, no later than 30 days after the occurrence of the change.

Any owner named herein may sign the application. That owner's name must appear in question #13 or #26. If the signatory is not an owner, attach a notarized affidavit that the individual is the authorized representative of the owner.

Print/Type owner's/representative's name & title	Signature	Date
Print/Type administrator's name	Signature	Date
Print/Type medical director's name	Signature	Date

# CHANGE OF OPERATOR/OWNER CONSENT FORM

I/We \_\_\_\_\_, current licensed operator of the home/facility listed below hereby grant notification to the Ohio Department of Health that a new individual or entity will be applying for a license for this home/facility.

## CURRENT

Operator/Owner Name		
Home/Facility Name		ID#
Home/Facility Address		
City	State	Zip

## NEW

Operator/Owner Name		
Address		
City	State	Zip

I understand that operation of the facility may continue while the above individual or entity's application is being processed as long as my license remains in effect. I hereby agree to preserve the validity of my license until final action is taken upon the application, unless I notify you in writing to the contrary. Further, I give my consent to the continued use of my license under the terms agreed upon by the applicant and myself. I understand that my license will be terminated upon issuance of a license to the applicant.

\_\_\_\_\_  
Print Name and Title

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

Ohio Department of Health, Office of Health Assurance and Licensing, Bureau of Licensure Operations  
246 N. High Street, Columbus, OH 43215  
(614) 466-7713