

HOSPICE CARE PROGRAM Change of Ownership Application Instructions

General Information and Instructions

Chapter 3712. of the Revised Code (RC) and Chapter 3701-19 of the Ohio Administrative Code (OAC) require all hospice care programs to be licensed, and set forth the conditions for licensure.

Chapter 3701-19-03(K) of the OAC states that hospice care programs shall notify the director, in writing, of any changes in the information contained in the statement of ownership made in the license application.

Notification of a change of ownership (a change in the business entity as registered with the Secretary of State) must be made no later than 15 days following the effective date of the change. To apply for a change of ownership (CHOW), please complete the "Hospice Care Program Licensure Application - HEA 8010" making sure to indicate the correct application type (Change of Ownership) in box 1 of the form.

For timely processing, you should submit your application along with the fee and the required documents within 15 days from the effective date of the change of ownership.

A nonrefundable check or money order, made payable to the Treasurer, State of Ohio in the amount of \$200 must accompany your application.

Required Documents

If the application includes a request for an in-patient facility, rule 3701-19-08 of the Ohio Administrative Code requires the submission of the following documents with your "Hospice Care Program Licensure Application" and fee:

1. Change of Operator/Owner Consent Form (HEA 8012)
2. Bill of Sale or other documentation evidencing a legal change of ownership
3. A copy of the Certificate of Occupancy Permit
4. An 8 1/2" x 11" schematic drawing (floor plan) of the facility that clearly shows patient rooms/bathroom facilities
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

If the hospice care program is requesting a waiver of the requirement for providing physical therapy, occupational therapy, or speech or language therapy services pursuant to rule 3701-19-19 of the Ohio Administrative Code, the application must include a written request for a waiver and documentation of:

- The number and location of all therapists in the area served by the program;
- The efforts that the program made to engage those therapists; and
- The efforts that the program made to encourage other therapists to serve the area.

Application Submission

A nonrefundable check or money order, made payable to the Treasurer, State of Ohio in the amount of \$200 must accompany your application.

Submit the completed CHOW 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 #2171
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.

Medicare and/or Medicaid Participation

A hospice care program must be licensed before it can be certified to participate in the Medicare and/or Medicaid programs.

If you have any questions regarding your hospice care program CHOW application, please e-mail the Licensure Program in the Bureau of Regulatory Operations, Ohio Department of Health at liccert@odh.ohio.gov or call (614) 466-7713.

Hospice Care Program Licensure Application

As defined in Chapter 3701-19 of the Ohio Administrative Code

Facility ID #

Please print legibly in ink or type

1. Application Type – Check one <input type="checkbox"/> New application <input type="checkbox"/> Renewal application <input type="checkbox"/> Change of ownership

2. Program name (DBA)			
3. Address			
4. City	5. Zip	6. County	7. Phone number
8. E-mail address			
9. Is in-patient care provided at this location? <input type="checkbox"/> No <input type="checkbox"/> Yes, provided by <input type="checkbox"/> hospice program <input type="checkbox"/> contract Facility type: <input type="checkbox"/> hospital <input type="checkbox"/> nursing home <input type="checkbox"/> other			
10. Counties served:			

Mailing address, if different from above

11. Name		
12. Address		
13. City	14. State	15. Zip

16. Are there other hospice care programs under this licensure not located at the above address? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes,	
Name	Name
Address	Address
City, State, Zip	City, State, Zip
County	County
Is in-patient care provided at this location? <input type="checkbox"/> No <input type="checkbox"/> Yes, provided by <input type="checkbox"/> hospice program <input type="checkbox"/> contract Facility type: <input type="checkbox"/> hospital <input type="checkbox"/> nursing home <input type="checkbox"/> other	Is in-patient care provided at this location? <input type="checkbox"/> No <input type="checkbox"/> Yes, provided by <input type="checkbox"/> hospice program <input type="checkbox"/> contract Facility type: <input type="checkbox"/> hospital <input type="checkbox"/> nursing home <input type="checkbox"/> other

Ownership

17.	
<input type="checkbox"/> Individual	<input type="checkbox"/> Partnership
<input type="checkbox"/> Association	<input type="checkbox"/> Corporation
<input type="checkbox"/> Limited Liability Co.	<input type="checkbox"/> Other
18. Tax Status <input type="checkbox"/> For profit <input type="checkbox"/> Not for profit	
19. Association/Affiliation	
<input type="checkbox"/> None	<input type="checkbox"/> Hospital
<input type="checkbox"/> Nursing home	<input type="checkbox"/> Home health agency
<input type="checkbox"/> Other	
20. Medicare Certified? <input type="checkbox"/> No <input type="checkbox"/> Yes, provider #	

21. Names of persons having ownership or control interest in the business entity

Name	Address	City/State/Zip

22. Business entity name (legal name as registered with the Secretary of State)

Address			
City	State	Zip	Charter/registration #

23. Corporate Officers/Partners/ LLC Members

Name/Title	Address	City/State/Zip	Telephone #

24. Statutory agent name

Address			
City	State	Zip	Phone number

25. How does your hospice program provide/intend to provide the following services?

Categories	Direct	Contract	Contractor's Name, Address, Phone Number
24-hour nursing services	<input type="checkbox"/>	<input type="checkbox"/>	
Physician services	<input type="checkbox"/>	<input type="checkbox"/>	
Medical supplies: drugs, biologicals & appliances	<input type="checkbox"/>	<input type="checkbox"/>	
Medical social services	<input type="checkbox"/>	<input type="checkbox"/>	
Physical therapy	<input type="checkbox"/>	<input type="checkbox"/>	
Occupational therapy	<input type="checkbox"/>	<input type="checkbox"/>	
Speech/language therapy	<input type="checkbox"/>	<input type="checkbox"/>	
Volunteer services	<input type="checkbox"/>	<input type="checkbox"/>	
Bereavement	<input type="checkbox"/>	<input type="checkbox"/>	
Counseling	<input type="checkbox"/>	<input type="checkbox"/>	
Short-term inpatient care palliative & respite	<input type="checkbox"/>	<input type="checkbox"/>	
Home health aide services	<input type="checkbox"/>	<input type="checkbox"/>	

Attestation

☐ By checking this box, I attest that the hospice care program has a written policy establishing procedures to be followed in preventing the diversion of controlled substances containing opioids that are prescribed to its hospice patients and this written policy is in compliance with Section 3712.062 of the Ohio Revised Code.

Affidavit

By signing below, I certify that to the best of my knowledge, the information provided in this application and the accompanying materials are true and accurate.

I acknowledge awareness of the provisions of the Ohio Revised Code which provide that any person who knowingly makes a false statement, or knowingly swears or affirms the truth of a false statement previously made, which the statement is made with purpose to secure the issuance by government agency of a license, is guilty of falsification, a misdemeanor of the first degree [Revised Code section 2921.13(A)(5) and (D).] A misdemeanor of the first degree is punishable by fine and/or imprisonment as provided in section 2929.21 of the Ohio Revised Code.

I also knowledge that pursuant to division (C) of section 3712.04 of the Revised Code, the Department may suspend or revoke a license if the licensee made any material misrepresentation in the application for the license.

If a representative of the applicant signs this affidavit, s/he must include documentation that s/he is the applicant's authorized representative.

Type/Print Applicant/Authorized Representative Name	Title
Signature	Date