



## CHANGE OF OWNERSHIP APPLICATION TITLE 18 SNF OR TITLE 18 SNF/ TITLE 19 NF

This letter is to inform applicants of the required documentation for a change of ownership application for Medicare and/or Medicaid certified health facilities. For additional information on the rules and regulations involving this action please refer to: <https://www.in.gov/health/files/A00162-1.pdf>

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**. Submitting 45 days prior to the proposed date is recommended. 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. 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. This form is available at <https://forms.in.gov/Download.aspx?id=4691>
2. State Form 19733, Implementing Indiana Code 16-28-2-6. This form is available at <https://forms.in.gov/Download.aspx?id=9627>
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. This form is available at <https://forms.in.gov/Download.aspx?id=6250>
5. Licensure Fee, payable by check or money order to the Indiana State 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. Form CMS-671, Long Term Care Facility Application for Medicare and Medicaid can be accessed at <https://www.cms.gov/medicare/cms-forms/cms-forms/downloads/cms671.pdf>
9. One (1) signed originals of the Form CMS-1561, Health Insurance Benefit Agreement can be accessed at <https://www.cms.gov/medicare/cms-forms/cms-forms/downloads/cms1561.pdf>
10. Documentation of compliance with Civil Rights should be filed online at <https://ocrportal.hhs.gov/ocr/aoc/instruction.jsf> per S&C 16-37
  - A copy of the online confirmation **from** OCR showing the provider has completed the civil rights submission online should be submitted to ISDH
11. Completed State Form 4332, Bed Inventory. This form is available at <https://forms.in.gov/Download.aspx?id=4659>

12. Facility floor plan on 8 ½" x 11" paper to show room numbers (must be legible) and number of beds per room, use multiple pages if needed.
13. Copy(s) of the Patient Transfer Agreement between the facility and local hospital(s)
14. SF 55283 Contract and Service Agreement Checklist and copy(s) of **new** Services Agreements/Contracts between the applicant entity and third parties. This form is available at <https://forms.in.gov/Download.aspx?id=11172>
15. SF 55282 Proposed Staffing Structure. This form is available at <https://forms.in.gov/Download.aspx?id=11170> and
16. Copy of the facility's disaster plan.
17. Approved CMS - 855A from the Medicare Fiscal Intermediary (FI). The facility must complete the 855A and submit it directly to their Medicare Fiscal Intermediary (FI) for review and approval. The form can be downloaded at <http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/cms855a.pdf> . Once the review has been completed the Fiscal Intermediary will forward the 855A (for both the buyer and the seller) along with their recommendation to the Indiana State Department of Health.

**NOTE:** The facility must contact the State Medicaid Agency or their 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 from the new owner and the approval or denial recommendation from the Fiscal Intermediary (FI), the Division of Long Term Care will forward appropriate documents to the Centers for Medicare and Medicaid Services ("CMS") and/or the State Medicaid Agency for processing;
4. The Fiscal Intermediary will forward to the facility its determination of the CMS-855A *Medicare General Enrollment Application*, and will copy the Division of Long Term Care and CMS;
5. CMS will forward to the facility a letter acknowledging the change of ownership, and will copy the Division of Long Term Care.

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 State Department of Health  
2 N. Meridian St., Section 4-B  
Indianapolis, IN 46204

**Bed changes should be submitted as a separate request.**

If you have any questions regarding the application process please contact Provider Services by email at [ltcproviderservices@health.IN.gov](mailto:ltcproviderservices@health.IN.gov) .