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

HOME MEDICAL EQUIPMENT
CHANGE OF OWNERSHIP PROCEDURES

1. Submit a notarized application along with the appropriate fee and a letter of intent 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 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. 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. 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. Please check this website periodically for updates.

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HOME MEDICAL EQUIPMENT
APPLICATION FOR CHANGE OF OWNERSHIP

All applicable laws, rules, policies, and guidelines affecting your practice are available for viewing at www.state.tn.us/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) $1,080

1. Geographic area served by Agency: (list county or counties) *If additional space is needed, please use a separate page.*

_____

_____

2. Number of branch offices: _____

Address of each branch office: *(If additional space is needed, please use a separate page)*

_____

_____

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 (_____) _____

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 or 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, please specify name of firm: _____

Phone Number (____) _____

_____

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: _____