



Bureau of Regulatory Operations Nursing Home Change of Operator Application Instructions

General Information and Instructions

A Change of Operator Licensure application must be submitted at least 30 days in advance of the proposed change. An Ohio Department of Health (ODH) inspection may be required if your facility has not been inspected within the past 15 months or the facility was cited for serious health or safety deficiencies on the most recent survey.

A check or money order, made payable to the Treasurer, State of Ohio in the amount of \$320 for each 50 beds or part thereof must accompany your application. See example below.

1 - 50 beds	\$320
51 - 100 beds	\$640
101 - 150 beds	\$960
151 - 200 beds	\$1,280
201 - 250 beds	\$1,600
251 - 300 beds	\$1,920

Required Documents:

The following documents must be submitted with your "Nursing Home Licensure CHOP Application" and fee:

1. 8 ½" x 11" schematic drawing (floor plan) of the facility that clearly shows the bath/toilet rooms, room numbers and number of beds in each room
2. A copy of the facility's Certificate of Occupancy permit
3. A copy of the facility's current State Fire Marshal Inspection in the last 15 months that reflect zero violations or that all violations have been corrected
4. A copy of the bill of sale
5. If the assignment or transfer **is not** in the form of a lease - Attestation signed by a Certified Public Accountant that the person has financial resources to cover any reasonably anticipated revenue shortfall for at least twelve months after the assignment or transfer that includes projected financial statements
6. If the assignment or transfer **is** in the form of a lease - A bond that has a term of at least twelve months, has an annual renewal, and is for the amount not less than one million dollars; or, if the person is unable to obtain a bond in the amount of one million dollars. An attestation signed by a Certified Public Accountant that the person has financial resources that are sufficient to cover any reasonably anticipated revenue shortfall for at least twelve months after the assignment or transfer that includes projected financial statements



7. An attestation signed by the person that the facility has Quality Assurance and Risk Management Plans
8. An attestation signed by the person verifying that the person has general and professional liability insurance coverage of at least one million dollars per occurrence and three million dollars aggregate

Application Submission:

Submit the completed change of operator 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 #3212
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.

Questions:

If you have any questions regarding your nursing home change of operator application, 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.



Nursing Home Licensure Application

Submit Application to: Ohio Department of Health
Revenue Processing #3212
PO Box 15278
Columbus, Ohio 43215

ODH USE ONLY for New App

App #

OHL #

1. Application Type Change of Operator	2. Projected opening date or effective date of change of operator	3. Ohio Building Use Group <input type="radio"/> I-1 <input type="radio"/> I-2
4. Capacity (# of Beds)	5. Operator Type <input type="radio"/> For Profit <input type="radio"/> Not For Profit	
6. Building Information <input type="radio"/> New Construction <input type="radio"/> Existing Construction Converted		7. CON File Number(s)

8. Facility Information

Facility Name (DBA)		
Previous facility name, if applicable		
Address		
City	Zip	County
Facility phone #	Fax #	
Facility e-mail address		
Administrator name		NHA license #
Administrator's business address, if different from operator <input type="checkbox"/> Same as operator		
City	State	Zip

9. Operator, if a Individual

Operator's Name		
Address		
City	State	Zip



Department of Health

Mike DeWine, Governor
Jon Husted, Lt. Governor

Amy Acton, M.D., MPH, Director

10. Operator, if a Business– Association, Corporation, Limited Liability Company, Partnership, Trust, or Estate

Operator's Business Name			
Address			
City	State	Zip	Phone #
Business activity type	Charter/Registration #		Date incorporated

11. Officers/Members/Partners of the Business Operator listed in question 10

President	Member	Partner
Vice President	Member	Partner
Secretary	Member	Partner
Treasurer	Member	Partner

12. Name of each person who has ownership interest of 5% or more in the Operator's business entity

Name	Name
Name	Name
Name	Name
Name	Name

13. Statutory agent of the operator (As Registered with the Secretary of State)

Name of Statutory Agent of Operator			
Address			
City	State	Zip	Phone #

14. If the Operator does not own the legal rights associated with the ownership and operation of the nursing home beds, enter the name of each person who has an ownership interest of five percent or more in the nursing home beds

☐ Not applicable

Name	Name
Name	Name
Name	Name



Department of Health

Mike DeWine, Governor
Jon Husted, Lt. Governor

Amy Acton, M.D., MPH, Director

15. Statutory Agent of the owner of the legal rights associated with the ownership and operation of the nursing home beds

☐ Not applicable

Name of Statutory Agent of Owner of the Nursing Home Beds			
Address			
City	State	Zip	Phone #

16. Does the operator own the building housing this long-term care facility? Y e s N o

If no, name of business entity that owns building and each person who has an ownership interest of five percent or more in the building and an address for building owner.

Business Entity Name			
Address	City	State	Zip
Name	Name		
Name	Name		
Name	Name		

17. Loan Information

Does Operator or Building Owner have a loan with the United States Housing and Urban Development (HUD) for this home?

☐ Yes, Name of Entity with HUD Loan

☐ No

18. Management firm or business employed to manage this long-term care facility.

☐ Not applicable

Management firm/business name			
Address			
City	State	Zip	Phone #

19. Name and address of any nursing home or any facility described in 3721.01(A)(1)(a) or (A)(1)(b) of the Revised Code located in this or another state in which the person (i.e. individual, corporation, business trust, estate, trust, partnership and association) has at least five years of experience as an operator, manager or administrator of a nursing home. The list shall include each currently or previously licensed nursing home in which the person has or previously had any percentage of ownership or experience as a manager or administrator. The percentage of ownership may have been in the operation, real property, or both, of the nursing home.

Name	Address
Name	Address
Name	Address
Name	Address



Department of Health

Mike DeWine, Governor
Jon Husted, Lt. Governor

Amy Acton, M.D., MPH, Director

20. Additional Questions

Yes No

Have you or any partner, member or officer listed in this application been convicted of a felony or a crime of moral turpitude?	
Are you or any member, partner or officer listed of this facility engaged in practices that could be construed as immoral?	
If the assignment or transfer is not in the form of a lease - Does the person to whom the operation is transferred or assigned have financial resources to cover any reasonably anticipated revenue shortfall for at least twelve months after the assignment or transfer?	
If the assignment or transfer is in the form of a lease - Does the person to whom the operation is transferred or assigned have a bond that has a term of at least twelve months, has an annual renewal, and is for an amount not less than one million dollars after the assignment or transfer?	
If the assignment or transfer is in the form of a lease and the person is unable to obtain a bond in the amount of one million dollars - Does the person to whom the operation is transferred or assigned have financial resources that are sufficient to cover any reasonably anticipated revenue shortfall for at least twelve months after the assignment or transfer?	
Does the person to whom the operation is assigned or transferred have quality assurance and risk management plans for the nursing home after the assignment or transfer?	
Does the person to whom the operation is assigned or transferred have general and professional liability insurance coverage that provides coverage of at least one million dollars per occurrence and three million dollars aggregate after the assignment or transfer?	

If you, any partner, officer, or person has answered "YES" to the questions above, please attach a separate document explaining

21. SPECIALIZED CARE PROGRAM - Check what specialized care or services your facility provides:

☐ N / A

<input type="checkbox"/>	Coma treatment	<input type="checkbox"/>	Respirator or ventilator care	<input type="checkbox"/>	Specialized Alzheimer's Disease
<input type="checkbox"/>	Neurological injury program for young adults	<input type="checkbox"/>	Traumatic brain injury program	<input type="checkbox"/>	Deaf or hearing impaired
<input type="checkbox"/>	Pediatric care	<input type="checkbox"/>	Amyotrophic lateral sclerosis	<input type="checkbox"/>	Adult day care program
<input type="checkbox"/>	Dialysis services	<input type="checkbox"/>	Hospice services	<input type="checkbox"/>	Other:



ATTESTATION

I, the undersigned, attest that:

- Person to whom the operation is transferred or assigned has sufficient capital or financial reserve to cover not less than twelve months' operation, including any reasonably anticipated shortfall and is financially able to operate the home in accordance with Chapter 3721. of the Revised Code and the applicable rules of the Ohio Administrative Code;
- Home is staffed, equipped and furnished to provide humane, kind and adequate treatment and care; and
- Home is in compliance with applicable zoning ordinances and rules.

By affixing my signature immediately below, I acknowledge awareness:

- Of the provisions of the Revised Code that provide that any person who knowingly makes a false statement or knowingly swears or affirms the truth of a false statement previously made when the statement is made with purpose to secure the issuance by a government agency of a license is guilty of falsification, a misdemeanor of the first degree (section 2921.13(A)(5) and (D)) of the Revised Code. A misdemeanor of the first degree is punishable by fine and/or imprisonment as provided in section 2929.21 of the Revised Code.
- That failure to timely provide all of the required information to the Ohio Department of Health will delay the on-site licensing inspection and issuance of my license, or void my application as being incomplete.
- That I cannot operate the home or admit more than two residents until I have been determined to be in compliance with the applicable licensing law and rules and have received my license.

I swear or affirm that the undersigned is:

- ☐ The operator, if the operator is an individual, or
- ☐ A duly authorized agent of the operator, if the operator is an association, partnership, limited liability company or corporation.

I further swear or affirm that the information provided herein, and any attachments hereto, have been prepared, or carefully reviewed, by me and constitute a truthful and correct disclosure of all information therein.

Name of undersigned:

Title:

Signature:

Date: