

Ohio Department of Health

**Hospice Care Program  
Change of Ownership Application**

**General Information and Instructions**

Chapter 3701-19-07(C) of the Ohio Administrative Code states that any change in any of the information specified in the license application of rule 3701-19-03, must submit the changes, in writing, to the director no later than 15 days after the change.

To apply for a change of ownership, please complete the Licensure Application and send the application along with the Consent form or bill of sale to the address below. No fee is required for a change of ownership.

Ohio Department of Health  
DQA/BIOS – Licensure Program  
246 N. High Street, 3<sup>rd</sup> Floor  
Columbus, OH 43215

Please note if your hospice currently is accredited or certified by an entity whose standards equal or exceed the Department's licensing standards established by Chapter 3701-19 of the Administrative Code, you must also submit the following:

1. Evidence of the program's current certification or accreditation noting the expiration date and the provider number or accreditation number; and
2. A copy of the accreditation or certification standards if the hospice is certified or accredited by an entity other than the United States Department of Health and Human Services (Medicare).

Hospice care programs which are accredited or certified by entities whose standards the Director determines to meet or exceed ours will be "deemed" as licensed and a license will be issued without an on-site visit. The Department will conduct an on-site visit of all other hospice care programs applying for licensure prior to issuing a license to determine compliance with Chapter 3701-19 of the Administrative Code.

To obtain online information regarding the licensure process, e.g. forms, rules (Ohio Administrative Code (OAC) and regulations (Ohio Revised Code (ORC)), visit the Ohio Department of Health web site at <http://www.odh.ohio.gov>. Questions regarding the licensure process may be directed to our e-mail address, [liccert@odh.ohio.gov](mailto:liccert@odh.ohio.gov) or by calling our office at (614) 466-7713.

# Hospice Care Program Licensure Application

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

ODH Use Only

App # \_\_\_\_\_ HSP  
OHL # \_\_\_\_\_

1. Application Type – **check one**

☐ New application                      ☐ Change of ownership                      ☐ Renewal application  
Opening date        /        /                      Effective date        /        /

2. Program name

3. Address

City

Zip

County

4. Phone number

5. E-mail address

6. Is in-patient care provided at this location? ☐ No ☐ Yes, provided by ☐ hospice program ☐ contract

Facility type: ☐ hospital ☐ nursing home ☐ other \_\_\_\_\_

Counties served:

7. Mailing address, if different from above  
Name

8. Address

City

State

Zip

9. Are there other hospice care programs under this licensure not located at the above address? ☐ No ☐ Yes If yes,

Name

Name

Address

Address

City, State, Zip

City, State, Zip

County

County

Is in-patient care provided at this location?

☐ No ☐ Yes, provided by ☐ hospice program ☐ contract

Facility type:

☐ hospital ☐ nursing home ☐ other \_\_\_\_\_

Is in-patient care provided at this location?

☐ No ☐ Yes, provided by ☐ hospice program ☐ contract

Facility type:

☐ hospital ☐ nursing home ☐ other \_\_\_\_\_

## Ownership

10. Ownership type

☐ Individual ☐ Partnership ☐ Association ☐ Corporation ☐ Limited Liability Company ☐ Other:

11. Tax Status

☐ For profit ☐ Not for profit

12. Association/Affiliation

☐ None ☐ Hospital ☐ Nursing home ☐ Home health agency ☐ Other:

13. Medicare Certified?

☐ No ☐ Yes, provider #

14. Names of persons having ownership or control interest

Name	Address	City/State/Zip

15. Business entity name

Address

City	State	Zip	Charter/registration #
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16. Corporate Officers

Name/Title	Address	City/State/Zip	Telephone #

17. Statutory agent name

Address

City	State	Zip	Phone number
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18. 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			
Physician services			
Medical supplies: drugs, biologicals & appliances			
Medical social services			
Physical therapy			
Occupational therapy			
Speech/language therapy			
Volunteer services			

18. Continued

Categories	Direct	Contract	Contractor's Name, Address, Phone Number
Bereavement			
Counseling			
Short-term inpatient care palliative & respite			
Home health aide services			

## 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.

Type/Print Applicant/Authorized Representative Name \_\_\_\_\_

Title \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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

HEA8010  
6/19/08

## 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. 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, DQA/BIOS - Licensure Program, 246 N. High Street, Columbus, OH 43215  
(614) 466-7713