*NOTICE *

THIS APPLICATION WAS REVISED IN APRIL 2008
– PLEASE READ CAREFULLY -

Change of Ownership License Application
To Operate a Hospital

Regulations affecting the application for licensure of Hospitals can be found by clicking the Rules tab or link on the applications page.

The application should be submitted to this office at least 30 days prior to the change of ownership. In addition to the information requested within the application, the following must also be submitted:

1. A completed license application and application fee of $200 plus $5 for each bed (excluding the first ten beds). Application fees are not refundable.

2. Organizational documents such as Articles of Incorporation, Articles of Organization, Partnership Agreement, LLC Agreement, or Statement of Sole Proprietorship under which the facility will operate. A copy of the registration to conduct business in Alabama must accompany this application if the entity was established in a state other than Alabama.

3. A draft copy of the transaction being considered, such as a lease, sales, or management agreement.

4. Approval of the change of ownership by the State Health Planning and Development Agency.

5. A facility diagram illustrating licensed and certified beds with room numbers. The diagram on letter sized paper is preferable.

Once the document consummating the change of ownership such as a bill of sale, signed lease agreement, etc., has been signed, a copy should be sent to this office. The new applicant is not permitted to operate the facility until all of the above items have been received, reviewed and a new license granted.

An on-site survey by the survey or regulatory staff may be required before the license can be granted.

NOTE Contact the department for ways to enhance the application to shorten the review time. The earliest date a license can be granted is the first day all documents and surveys have been approved by the department.
For state licensure purposes, a change of ownership is not effective until a new license certificate has been issued.

Please note: it is a violation of state law to provide hospital services before you are granted a license from this agency. If you have questions regarding your application, please call (334) 206-5175.

ADDITIONAL INFORMATION
CHANGE OF OWNERSHIP
HOSPITAL

Item 1, Applicant. The applicant is the individual, partnership, corporation or other entity which will be the governing authority of the facility and to whom the license will be granted **(not the facility name or the individual completing the application, unless the applicant is an individual)**. The name entered in this section must be exactly as printed on the legal document establishing the entity. A copy of the legal document must accompany this application. Entities established in a state other than Alabama must register to conduct business in Alabama with the Secretary of State's Office. A copy of the registration must also accompany this application. If the facility is leased, the lessee should be indicated as the applicant. The lessee may be an individual, partnership, corporation, or other entity. . **NOTE - The applicant must be the operator of the facility, the entity that hires or fires the administrator, determines patient care issues, makes payment for facility obligations, etc.**

Item 6, Bed Capacity and Authorized Bed Capacity. Bed capacity is the number of beds the facility wishes to have licensed. This number cannot exceed the number of Certificate of Need beds. Authorized bed capacity is the number of beds a hospital has available for inpatient care. The number of authorized beds is designated by the hospital administrator (it may be less than, but **not more than,** the licensed bed capacity).

Item 7, Facility Name. The information provided on this line will be entered in the Provider Services Directory and the facility will be referred to by this name exactly as entered on this application. This name should be the same as on advertisements, facility letterhead, signs in front of the facility and certification information. This name must be unique; that is, it may not be the same as the name of any other licensed facility in Alabama, nor may it be so similar to the name of any other licensed facility that, in the judgment of ADPH staff, there could be any confusion to the public. Governing authorities operating more than one facility may give the facilities they operate similar, but not identical names. The name may be abbreviated if the abbreviation is also used on advertisements, facility letterhead, signs in front of the facility and certification information.

Item 9, Facility Mailing Address. The facility mailing address, street address or post office box must be within the same postal service area as the facility's physical location.

Item 15, Hospital Classification. Any specialty listed in this section must be consistent with the specialty stated on the Certificate of Need.

Item 21, Attestation of Responsible Person. A company officer, board member, administrator or other responsible person must sign the application and make the attestation.

Application Fee. The application fee for a hospital is $200 plus $5 for each bed, excluding the first ten beds. Application fees are not refundable. Make a check or money order payable to the Alabama Department of Public Health.

Attachments. Each attachment must be referenced as a specific applicable item. For example, attachment to item 14 d should be referenced in the document and labeled as such.

(Rev. 4/2008)

STATE OF ALABAMA
DEPARTMENT OF PUBLIC HEALTH
DIVISION OF PROVIDER SERVICES
P.O. BOX 303017 (MAILING ADDRESS)
MONTGOMERY, ALABAMA 36130-3017
THE RSA TOWER, SUITE 680, 201 MONROE STREET, MONTGOMERY, AL 36104
(PHYSICAL LOCATION)

CHANGE OF OWNERSHIP LICENSE APPLICATION TO OPERATE A HOSPITAL

1.____________________________________
Applicant
(see instructions on page 2)

2.____________________________________
Applicant Address

3.____________________________________
City State Zip Code

4.____________________________________
Applicant Telephone Number

5.____________________________________
Facility Administrator

6.____________________________________
Bed Capacity Authorized Bed Capacity
(see instructions on page 2)

7.____________________________________
Facility Name
(see instructions on page 2)

8.____________________________________
Facility Physical Address

9.____________________________________
Facility Mailing Address
(see instructions on page 2)

10. ____________________________________
City Zip Code County

11. ____________________________________
Facility Telephone Number

12. ____________________________________
Facility ID

13. This application is to apply for (check one):

a. Change of ownership ☐ b. Change of ownership and name change ☐

The facility is currently licensed as ____.
(Facility name)

APPLICATION FEE	**FOR DEPARTMENTAL USE ONLY**
APPLICATION FEES ARE NOT REFUNDABLE. The fee is $200 plus $5 for each bed, excluding the first ten beds	Classification ________________________
	Bed Capacity ______ Auth. Bed Capacity ________
	Application Fee _________ Check # __________
MAKE CHECK OR MONEY ORDER PAYABLE TO: ALABAMA DEPARTMENT OF PUBLIC HEALTH	Facility ID # ________ Date Lic. Issued __________
	License Type and # ______________________

14. Applicant Information

a. Applicant is a (check one):

Individual	☐	Nonprofit Corporation	☐	City	☐
Partnership	☐	Hospital Authority	☐	County	☐
Corporation	☐	State	☐	Joint City County	☐
Limited Liability Company	☐	Other: ______________________ (Specify)			☐

b. List all the applicant's board members and officers (attach additional paper if necessary).

________________________ ________________________

________________________ ________________________

________________________ ________________________

________________________ ________________________

c. List the name(s) of any person or business entity that has 5% or more ownership interest in the applicant (attach additional paper if necessary). Also, attach a diagram depicting the organizational structure.

________________________ ________________________

________________________ ________________________

________________________ ________________________

________________________ ________________________

d. Does this applicant or any of its owners listed in item "c" operate any other health care facility in Alabama or in any other state? YES ☐ NO ☐ If yes, attach a list including the type(s) of facility(s), name(s), address(s), and owner(s).

e. Have any of the facilities listed in item "d" had any adverse licensure action taken against them or been subject to exclusion from the Medicare or Medicaid Reimbursement Programs?
YES ☐ NO ☐ If yes, attach an explanation.

f. Have the applicant, officers or principals ever had a license application denied by this or any other state? YES ☐ NO ☐ If yes, attach an explanation.

15. Has the facility administrator listed in item “5" of this application:

    a. ever been convicted of a crime? YES ☐ NO ☐

    b. ever been found guilty of abusing another individual? YES ☐ NO ☐

    c. ever had adverse action taken against a professional license for example, nursing home administrator license, attorney license, nurse license, physician license? YES ☐ NO ☐

    d. ever been excluded from participation in Medicare or Medicaid Reimbursement Program? YES ☐ NO ☐

    If a, b, c, or d are yes, attach an explanation for each affirmative answer.

16. Hospital Classification

    This hospital will operate as a (check one):

    ☐ general hospital

    ☐ specialized hospital. The specialty is ____.
    (see instructions on page 2)

17. Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

    This facility is / is not currently JCAHO accredited. Under the ownership listed in Item 1 of this
    (circle one)

    application this facility will / will not seek JCAHO accreditation.
    (circle one)

18. Are there any outstanding citations of deficiency, either Federal or State, that have not been corrected? YES ☐ NO ☐

    If checked yes, has the plan of correction for these deficiencies been accepted by the Division of Health Care Facilities? YES ☐ NO ☐

    Note: The new operator will be responsible for correcting all outstanding deficiencies and may be subject to sanctions imposed for past or present deficiencies, including payment of any uncollected civil monetary penalties.

19. Provide the name, phone number, and email address of a knowledgeable person who can supply details about this application.

    Name (print) ____________________________Address___________________________________

    Phone _________________________ Email ____

20. Administrator Signature:

I declare, under penalty of perjury, that I have not operated or allowed to be operated this facility, or any other facility, without a license. I agree to operate this facility according to the Rules of the Alabama State Board of Health.

______________________________ ______________________________

Printed Name Signature

____

Date

NOTARIZED:

Sworn to and subscribed before me this ________

day of ____________ 20_____.

____

(Notary Public)

21. Attestation of Responsible Person:

I declare, under penalty of perjury, that I have personal knowledge about the statements made in this application and certify that all statements are true and correct. To the best of my knowledge, neither the applicant nor any of the principals, including myself, the owners, and the administrator, have operated or allowed to be operated this facility, or any other facility, without a license. I certify that I am authorized to make this representation on behalf of the applicant.

Signature: ____ Date: ________________________

Title/Position: _____________________________________

NOTARIZED:

Sworn to and subscribed before me this ________

day of ____________ 20_____.

____

(Notary Public)

22. Current Licensee Signature

The current licensee of this facility concurs with this change of ownership and recommends that this change of ownership application be granted. I certify that I am authorized to make this representation on behalf of the current licensee.

____
Name of Current Licensed Entity

____
Signature

____
Date

____
Printed Name

NOTARIZED:

Sworn to and subscribed before me this _____

day of ____________ 20_____.

____
(Notary Public)

MANDATORY ACKNOWLEDGMENT NOTICE

Pursuant to *Alabama Code* section 30-3-194, every applicant seeking from a state agency a license, certificate, permit, or authorization to engage in a profession, occupation, or commercial activity, must provide the social security number of the person signing the application, whether as an individual or on behalf of an entity or corporation. Failure to provide this social security number will result in the denial of the application.

Print or Type Name of Person Signing Application: ______________________________

Social Security Number of Person Signing Application: __________________________

Print or Type the Facility Name: ____

THIS PAGE **NOT** FOR PUBLIC RECORD