**MARYLAND HEALTH CARE COMMISSION**

**Notice of Acquisition / Transfer of Ownership Interest of a Home Health Agency**

Please complete this form in order to assure that you provide all of the information needed for the MHCC to issue a determination of CON coverage under **COMAR 10.24.01.03A** when a person intends to acquire a Home Health Agency (HHA), or when there is a 25% or greater change in ownership of a HHA*.***Note that an affirmation regarding the accuracy of the information provided must be signed by an authorized individual. *Supplying MHCC with a Word version of your letter and this form would help ensure a timely response. Please submit all forms and correspondence to*** [***mhcc.confilings@maryland.gov***](file:///C%3A%5CUsers%5Cddunn%5CDownloads%5Cmhcc.confilings%40maryland.gov)

**Name, Address, and Current HHA License # of AGENCY *BEING ACQUIRED*:**

Agency Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

License #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name and address of *ACQUIRING ENTITY*:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| In addition to completing the information in the table below, please provide a separate narrative summarizing the proposed acquisition / transfer of ownership interest. Unless otherwise stated, the information provided should refer to the ENTITY BEING ACQUIRED. (Form will expand to accept lengthier responses but use additional pages if needed.) |
| 1 | The name and address of the agency post-acquisition. |  |
| 2 | Describe the corporate structure and affiliations ***of the purchaser.*** *Attach a chart that completely delineates the ownership structure.* |  |
| 3 | Please provide some background on ***the acquiring organization,*** i.e., who are they, when founded, where have they provided services? |  |
| 4 | The operator of the HHA (and the relationship of the operator to the owner).  | **Current** | **After transaction** |
|  |  |
| 5 | Disclose whether any of the ***purchaser’s*** principals have ever pled guilty to, or been convicted of, a criminal offense in any way connected with the ownership, development, or management of a health care facility, including Medicare or Medicaid fraud or abuse in the last 10 years.. |  |
| 6 | a) Describe the range of health care services provided by the HHA. |  |
| b) Will the services change as a result of the acquisition? If so, how?Note: A purchaser shall affirm that it will provide, at a minimum, the services historically provided by the HHA being acquired |  |
| 7 | a) Jurisdiction(s) served currently |  |
|  | b) Jurisdiction(s) to be served after acquisition |  |
| 8 | Number of admissions for the prior calendar year. |  |
| 9 | Gross operating revenue generated during the last fiscal year. |  |
| 10 | Purchase price. |  |
| 11 | Source of funds. |  |
| 12 | If the acquiring entity is an existing Medicare-certified HHA provider:1. disclose condition-level deficiencies cited in the two most-recent survey cycles, and;
 |  |
| 1. if such deficiencies, document completion of any required plan of correction.
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| 13 | Will the acquiring entity be taking automatic assignment of the existing Medicare provider number?--If no, what is the expected timeline for obtaining Medicare certification, as well as plans for operation prior to obtaining Medicare certification. |  |
| 14 | a) Does the existing HHA currently have a Medicaid contract? |  |
| b) If yes, will the purchaser/acquiring entity agree to continue to be bound by that contract? |  |
| 15 | Anticipated date of closing or transfer. |  |
| 16 | Purchaser affirms a commitment to serving Medicare, Medicaid, commercial, self-pay and uninsured clients, as well as to providing charitable services and reduced charge services for indigent and low-income clients. (COMAR 10.24.16.11C.)**Note: Provide a yes or no response.** |  |
| 17 | Purchaser affirms a commitment to collaborating with the Seller in providing a full 12-months of data to the Commission’s Annual HHA Survey for the reporting year in which the acquisition occurs and the purchaser shall agree to participate in the Annual HHA Survey going forward. **Note: Provide a yes or no response.** |  |

The Notice of Acquisition must be accompanied by an affirmation attesting to the truthfulness of the information provided by the purchaser. The form for the affirmation is below.

Affirmation of Purchaser/Acquiring Entity/Transferee

 I solemnly affirm under penalties of perjury that the information provided to the Maryland Health Care Commission regarding the proposed acquisition or transfer of ownership interests of the above-named facility is true and correct to the best of my knowledge, information, and belief, and that I have been duly authorized by the purchaser/ acquiring entity/ transferee to provide this information on its behalf.

Date signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature

 [Name and Title]

 [Company]

 [Address]

 [Phone]

 [E-Mail]

cc: [local health officer]

 Oksana Likhova, Office of Health Care Quality

 Deanna Dunn, Health Facilities Coordinator, MHCC

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