MARYLAND HEALTH CARE COMMISSION

Notice of Acquisition / Transfer of Ownership Interest of a Hospice Agency

Please complete this form to assure that you provide all 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 Hospice Agency, or when there is a 25% or greater change in ownership of a Hospice. **Note that an affirmation regarding the accuracy of the information provided must be signed by an authorized individual.**

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

Agency Name: _____

Address: _____

License #: _____

Name and address of *ACQUIRING ENTITY*:

Name: _____

Address: _____

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	COMAR 10.24.01.03A(1)(c) requires an org chart that describes the ownership of the hospice prior to and after the proposed acquisition.		
3	Please provide some background on ***the acquiring organization,*** i.e., previous names, who are they, what us their history, when founded, where have they provided services?		
4	The operator of the Hospice (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. Provide details.		
6	Describe the health care services currently provided by the Hospice. Will any services change because of the acquisition? If so, how?		

	Note: A purchaser shall affirm that it will provide, at a minimum, the services historically provided by the Hospice being acquired	
7	a) Jurisdiction(s) served currently and 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 Hospice provider disclose all condition-level deficiencies cited in the two most-recent survey cycles, and if there are deficiencies, document completion of any required plan of correction.	
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	Does the existing Hospice currently participate in Medicaid? If yes, will the purchaser/acquiring entity agree to continue participating with Medicaid?	
15	Anticipated date of closing or transfer.	
16	Purchasers affirm a commitment to serving Medicare, Medicaid, commercial, self-pay and uninsured clients, as well as providing charity care and reduced charge services for indigent and low income clients. **Note: Provide a yes or no response.**	
17	Purchaser affirms a commitment to collaborate with the Seller to provide a full 12-months of data to the Commission in completing the Annual Hospice Survey for the reporting year in which the acquisition occurs and the purchaser shall agree to participate in the Annual Hospice 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
Office of Health Care Quality