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August 3, 2015

Donna Jerry, Senior Health Policy Analyst
Judith Henkin, Policy Director
Green Mountain Care Board
89 Main Street
Montpelier, VT 05620

Re: Request for No Jurisdiction Determination – Proposed Affiliation Agreement between Visiting Nurse and Hospice for Vermont and New Hampshire and Dartmouth-Hitchcock Health

Dear Donna and Judy:

Pursuant to 18 V.S.A. § 9440(c)(2)(A), the Visiting Nurse Association and Hospice of Vermont and New Hampshire (VNH) submits this letter requesting that the Green Mountain Care Board (GMCB) find that VNH's proposed affiliation with Dartmouth-Hitchcock Health System (D-HH) does not fall within the GMCB's Certificate of Need (CON) review jurisdiction, or in the alternative that it is excluded from jurisdiction under 18 V.S.A. § 9435(d) because the Commissioner of the Department of Disabilities, Aging and Independent Living (DAIL) will be reviewing the affiliation under its authority over the designation and the redesignation of home health agencies as set forth in Chapter 63 of Title 33 of the Vermont Statutes.

VNH is the agency designated under 33 V.S.A. § 6304(b)(12) to provide home health services in the cities and towns of Windsor County, Windham County, Orange County (with the exception of the towns of Orange, Washington, and Williamstown) and the towns of Hancock, Granville, Searsburg, Readsboro, Stamford, Landgrove, Winhall, and Peru. VNH provides home health services in both Vermont and New Hampshire, including nursing, rehabilitation, hospice, and personal care service, to enhance the health status of individuals in the communities it serves. Its service area covers approximately 140 towns between the two states.

In an effort to further its charitable mission, VNH intends to enter into an affiliation agreement with D-HH that will optimize the use of resources to improve quality, outcomes and access to care, while meeting the health needs of the community. Under the affiliation agreement, VNH will become integrated into D-HH through a corporate member governance structure in which D-HH will become the sole member of VNH. In this role, D-HH will have certain reserved powers substantially similar to reserve powers it now holds as a member of each of several affiliated nonprofit hospitals, including one in Vermont. Vermont's CON law provides different review threshold for non-hospital healthcare facilities under 18 V.S.A. § 9434(a). This letter is written to explain why the proposed affiliation between VNH and D-HH should not be subject to certificate of need review.

A. Vermont CON Statutes and Regulations

Vermont statutes require a health care facility to seek the issuance of a CON when the facility is developing a new health care project. 18 V.S.A. § 9434. A new health care project includes "the offering of any home health service, or the transfer or conveyance of more than a 50 percent ownership interest in a health care facility other than a hospital." 18 V.S.A. § 9434(a)(3). The Vermont statute is limited specifically in scope to "the transfer or conveyance of more than a 50 percent ownership interest." The legislature chose not to include "a change in control" or "a change in authority" in the description of a health care project subject to CON review.

Vermont CON regulations interpret the above jurisdictional provision as including "a change in ownership, corporate structure or other organization modification such that a new license from the appropriate state or federal licensing entity is required" (emphasis added). GMCB Rule 4.203(1). The regulations also provide that a transfer or conveyance of ownership "that fundamentally changes the financial stability or legal liability of the facility shall be a new health care project." GMCB Rule 4.203(2).

B. Description of Proposed Corporate Affiliation

As a nonprofit organization, VNH is a corporate entity that does not have owners. Under the proposed affiliation, the corporation is not being sold, transferred or conveyed to someone else. It is not a merger of one corporation into another. The proposed affiliation agreement between D-HH and VNH establishes D-HH as the sole member of the VNH nonprofit corporation and defines the powers of the VNH Board and of D-HH. Nonprofit membership does not constitute a proprietary interest in the nonprofit corporation. Vermont law provides simply that members of nonprofit corporations are defined under law as individuals who have a right under the corporate articles or bylaws of the corporation to vote for a director or directors on more than one occasion, to cast a single vote and to call a meeting in certain circumstances. 11B V.S.A. §1.40(21) and (22). D-HH, as a member of a nonprofit, will not be liable for any acts, debts, liabilities or obligations of VNH. 11B V.S.A. § 3.02 *and* 11B V.S.A. § 6.22.

After the proposed affiliation, the VNH will remain the same Section 501(c)(3) corporation it is today with the same mission "dedicated to delivering outstanding home health and hospice services that enrich the lives of the people we serve." The VNH will continue to operate as a stand-alone licensed home health and hospice agency as it does today, available to provide services to the residents of more than 140 towns in Vermont and New Hampshire. The affiliation will cause no particular change in its management or financial structure nor will it affect VNH's legal liability exposure. The VNH will retain control over its financial investments and all funds allocated to the VNH by the communities it serves. The VNH will have, however, enhanced opportunities to collaborate with tertiary and community based providers, to work on innovative care models and to improve its clinical practice. It will benefit from access to best practices in quality improvement, clinical services, research, information technology, financial planning and administrative services.

The VNH will become a community based corporate affiliate of a regional health system focused on improving population health. The VNH's governance will be linked to that of D-HH

through reserved powers. D-HH's role will be to approve and ratify the VNH Board's actions related to its budget, material borrowings, material program decisions, Board nominations, CEO selection and amendments to corporate documents. It directly will appoint one-third of the Board members, but not the Chair. The one-third Board representation by D-HH will meet all VNH Board member requirements, including that a majority are individuals or family of individuals being served by VNH. The VNH CEO will report to both the VNH Board of Trustees and to the D-HH CEO. The transfer of these reserve powers to D-HH as part of the proposed affiliation is a change in control affecting the governance of the VNH. The one-third Board representation falls short of a majority that might then implicate the proposed affiliation as a change in ownership under the statute.

C. DAIL's Jurisdiction over Home Health Agency Designation

The Home Health Act of 2005, codified in Vermont Statutes in Chapter 63 of Title 33, designated geographic service areas for twelve nonprofit home health agencies, including the VNH. The designation granted the home health agency a franchise to provide home health services within its designated geographic area and the obligation and responsibility to do so for a four-year designation term. The Commissioner of DAIL was given authority over home health agency designations, redesignations and designation revocation. Designations for "new home health agencies" require CON approval by the GMCB, while redesignation applications are reviewed by the Commissioner of DAIL. 33 V.S.A. § 6304. The Certificate of Need statute specifically excludes from certificate of need review "redesignations, designation revocations and collaborative agreements of home health agencies subject to the supervision of the commissioner of disabilities, aging and independent living." 18 V.S.A. § 9435(d).

D. DAIL's Review of Proposed Affiliation's Impact on VNH Designation and Service Delivery

On June 30, 2015, the VNH requested that DAIL consider whether the proposed affiliation between VNH and D-HH would affect its Vermont home health agency designation under 33 V.S.A. § 6304 or its licensure. In response, by letter dated July 27, 2015 from DAIL general counsel, Stuart Schurr, the VNH was advised that "to ensure that the proposed affiliation will not result in a change in service delivery, DAIL requires VNH to complete and submit for approval to DAIL's Division of Licensing and Protection, [a...] Designation Application (letter attached). Mr. Schurr considered that the proposed affiliation appears to "constitute a transfer of authority from VNH to D-HH" which is prohibited by Section 3.15 of the Home Health Regulations. Essentially, DAIL concluded that the proposed affiliation is a change of control to be reviewed under its home health agency designation jurisdiction.

E. Conclusion

The affiliation proposed between the VNH and D-HH will constitute a change in control of a home health agency subject to home health agency designation jurisdiction by the Commissioner of DAIL. As a result, the VNH will resubmit a designation application to the Division of Licensing and Protection for its review to ensure that the proposed affiliation will not result in a change in service delivery. We request that the GMCB Rule that the proposed affiliation does

not fall into certificate of need review jurisdiction as it is not a transfer or conveyance of an ownership interest. In the alternative, if certificate of need review jurisdiction does exist, we request that a determination that the affiliation is excluded under 18 V.S.A. § 9435 as a designation or a redesignation review of a currently designated home health agency subject to the supervision of the Commissioner of DAIL.

VNH understands that the GMCB may confer with DAIL or its Division of Licensing and Protection with regard to this request. It would be very helpful if either legal counsel or the Board could respond to this inquiry at its earliest convenience. Please do not hesitate to contact us by phone or mail with questions. We greatly appreciate your consideration.

Sincerely,

Anne Cramer
Lauren Layman

Enclosure

cc: Michael Donofrio

Commissioner's Office
103 South Main Street
Waterbury VT 05671-1601
Voice/TTY 241-2626
Fax (802) 241-2325

July 27, 2015

Anne E. Cramer, Esq.
Primmer Piper Eggleston & Cramer, P.C.
150 South Champlain Street
P.O. Box 1489
Burlington, Vermont 05402-1489

Dear Anne:

Thank you for your letter, dated June 30, 2015, in which you reference the proposed affiliation between the Visiting Nurse Association of Vermont and New Hampshire ("VNH") and Dartmouth-Hitchcock Health ("D-HH"). Enclosed with that letter was documentation intended to assist the Department of Disabilities, Aging and Independent Living ("DAIL") in determining whether the proposed affiliation would affect VNH's home health agency designation.

You assert that the proposed affiliation will result in a change in control of the VNH corporation, but not in a change in ownership or management. Even if the proposed affiliation were to constitute a change in ownership or management, however, you further argue that Section 3.14 of the Regulations for the Designation and Operation of Home Health Agencies ("Home Health Regulations") merely requires VNH to disclose to DAIL the information required in Section 3.6 of the Home Health Regulations, not to request and obtain a new license. Having reviewed the submitted documents, dated June 30 and July 21, 2015, and having considered the statements made during our meeting on July 8, 2015, DAIL respectfully disagrees.

Notwithstanding your statement that VNH and D-HH have compatible missions and your assurances that the affiliation will enhance the services delivered by VNH, the documents provided make clear that by becoming the sole corporate member of VNH, D-HH will have reserved powers including, but not limited to, the approval of decisions of the VNH Board of Trustees, the approval, without limitation, of one-third of the members of the VNH Board, the ratification of the two-thirds of the members nominated by the non-D-HH appointed Board members, the approval of budgets, strategic plans and policies of VNH, the approval of borrowings and dispositions of assets by VNH, the approval of the dissolution or liquidation of

VNH, even after approval by the VNH Board, and the final approval of any action or plan initiated or approved by the VNH Board. The contemplated governance structure of the VNH which, as acknowledged in your letter dated July 21, 2015, will result in the "transfer of these reserve[d] powers to D-HH," would appear to constitute a transfer of authority from VNH to D-HH. Transfers of authority are addressed in, and prohibited by, Section 3.15 of the Home Health Regulations.

Accordingly, in order to ensure that the proposed affiliation will not result in a change in service delivery, DAIL hereby requires VNH to complete and submit for approval to DAIL's Division of Licensing and Protection, the enclosed Designation Application. Please contact Suzanne Leavitt, RN MS at suzanne.leavitt@state.vt.us or (802) 871-3317, and she will assist you in this matter.

Sincerely,

Stuart G. Schurr
General Counsel

Enclosure
cc: Suzanne Leavitt, RN MS

Agency of Human Services
Department of Disabilities Aging & Independent Living
Division of Licensing & Protection
103 South Main Street, Ladd Hall
Waterbury, Vermont 05671-2301

Home Health Agency Designation Application

Please submit one original and one copy of the application and all attachments.
This application and all attachments are subject to Vermont public records law.

SECTION I – IDENTIFYING INFORMATION

Legal Name of Home Health Agency (HHA): _____

Name of Corporation (if different): _____

Administrative/Mailing Address: _____

_____

_____

HHA CMS Certification # _____ Hospice CMS Certification # _____

HHA National Provider # (NPI) _____ (# of Parent Agency)
(10 digit #)

Administrative Officers

Agency Director: _____

Director of Patient Services\Clinical Director: _____

Chief Financial Officer: _____

Contact Person for questions about this application: _____

Phone: _____ email: _____

Subunit/Branch addresses: If you have more than two HHA sites, please include a list of the additional addresses as ***Attachment A.***

	Site #1	Site #2
Name:		
Street:		
City/Zip:		
Phone #:		
Contact Person:		
	Yes No Yes No Branch ☐ ☐ Subunit ☐ ☐	Yes No Yes No Branch ☐ ☐ Subunit ☐ ☐
Designated Area		
CMS Identifier #:		

1. Does the HHA provide the following services? (Please check all that apply):
   - ☐ Medically necessary home health services (as defined by Medicare Conditions of Participation)
   - ☐ High-Tech Services (nursing, home health aide) (state run High-Tech programs)
   - ☐ Hospice services (as defined by Medicare Conditions of Participation)
   - ☐ Choices for Care Services
     - ☐ Personal Care
     - ☐ Respite Care
     - ☐ Companion Care
     - ☐ Case Management
     - ☐ Homemaker
   - ☐ Adult Day Services
   - ☐ TBI (Traumatic Brain Injury)
   - ☐ MCH (Maternal Child Health)
2. List specific Home Health care services provided , not already listed:

   _____
3. What Services are provided thru contract with another provider?

   _____
4. Home Health Agency: ☐ Non-profit ☐ Proprietary

SECTION II – ACCREDITATION STATUS

Please check the box over the column below that accurately describes the HHA's accreditation status with the Centers for Medicare and Medicaid Services (CMS) and complete the applicable questions in that column; and

Include as ***Attachment B:***

- an explanation of any changes in **JOINT COMMISSION/CHAP** status that have occurred in the past four years.

JOINT COMMISSION /CHAP-accredited Home Health Agency's please note:
Please include a copy of your HHA's JC/CHAP accreditation certificate and include that with ***Attachment B***

☐	☐	☐	☐	☐
The HHA is not accredited by JC. It has been certified as eligible for Medicare reimbursement by CMS based on a survey conducted by the Division of Licensing and Protection of the Vermont Department of Disabilities, Aging and Independent Living.	The HHA is accredited by JC and it has been deemed to be eligible for Medicare reimbursement by CMS through JC accreditation.	The HHA is accredited by CHAP and has been deemed eligible for Medicare reimbursement by CMS through CHAP accreditation.	The HHA is not currently accredited by JC/CHAP and is not certified by CMS	The HHA is accredited by Joint Commission or CHAP and receives CMS survey for certification\recertification through Licensing and Protection of the Vermont Dept of Disabilities, Aging & Independent Living
Date of most recent full survey conducted by the state survey agency for purposes of CMS certification: _____	Date most recently accredited by JC: _____ Status of current JC accreditation: _____ Full _____ Provisional _____ Conditional If current status is Provisional or Conditional accreditation, please explain in a separate document and include with ***Attachment B.***	Date most recently accredited by CHAP: _____ Status of current CHAP accreditation: _____ Full _____ Provisional _____ Conditional If current status is Provisional or Conditional accreditation, please explain in a separate document and include with ***Attachment B.***	Date HHA decertified by CMS: _____ Please explain why the HHA is not certified by CMS in a separate document and include with ***Attachment B.***	Date most recently accredited by Joint Commission/CHAP (not deemed) _____ Full _____ Provisional _____ Conditional

SECTION III – PATIENT RIGHTS [18 V.SA. 42 § 1852]

Patient Rights Notice: Please check the box next to each item to verify the HHA's compliance with that item. If the HHA is not currently in full compliance with an item(s), please include an explanation in ***Attachment C.***

The Home Health Agency's current Patient Rights notice:

- ☐ is written in clear language and in easily readable print;
- ☐ is distributed to patients upon admission;
- ☐ indicates that as an alternative or in addition to the HHA's complaint procedures, the patient may contact the licensing agency and provides the 800 hot line to do so.

Please include a copy of the Home Health Agency's Patient Rights notice as *Attachment C.*

SECTION IV – ORGANIZATION

*"**Regulation**" refers to Regulation for the Designation and Operation of the Home Health Agency

Yes	No	**As part of the application, the following are submitted under *Attachment D.***
☐	☐	A list of all the board members, officers, partners and key administrative staff and their titles, including the names of the administrator and the director of nursing or equivalent; with copies of current licenses for all licensed agency staff.
☐	☐	Proof of the certificate of need (CON) for the area where designation is sought.
☐	☐	Proof of Medicare Certification.
☐	☐	The number of full time equivalent employees by discipline (full time 37.5-40 hours, part time<37.5 hours)
☐	☐	An organizational chart showing all reporting and supervisory relationships.
☐	☐	A current local community services plan. See 3.8 of the *Regulation for outline of components to be included in this plan. Revisions must be made and submitted at least every 4 years.
☐	☐	The annual HHA audit report and any other financial audits, as well as, copies of the HHA's Medicare cost reports (3.12 of the Regulation). Statements from the agency's independent auditor assuring compliance with general accepted accounting standards and assurance that the financial reports are an accurate representation of the Agency's financial condition.
☐	☐	A copy of the HHA's disaster plan and protocols
☐	☐	Data requirements to include: All complaint information, patient wait lists, numbers of ineligible patients for services, numbers of eligible patients not receiving services, number of patients served under 65 years of age, number of patients served over 65 years of age and a summary of patient surveys. For underinsured, or low income persons, please provide the total number of visits and hours of service provided to include charitable and subsidized programs. (6.10 of the Regulation)

Yes	No	N/A	
☐	☐	☐	A Disclosure of Ownership form upon request from State Licensing Agency.
☐	☐	☐	The name of each person, firm or corporation having direct or indirect ownership interest of 5% or more in the HHA, and each physician with financial interest or ownership of any amount in the HHA, and the amounts of ownership for all.
☐	☐	☐	A copy of the most recent national accreditation status, if applicable.
☐	☐	☐	Any collaborative, or shared, service agreements with other HHA. (3.17 of the Regulation)
☐	☐	☐	A copy of the most recent fee schedule. (6.8 of the Regulation)

AGENCY ATTESTATION OF COMPLIANCE

Yes	No*	
☐	☐	Record of compliance with all relevant regulations and laws, (i.e., Life Safety Codes, Clinical Laboratory Improvement Amendment Certificate (CLIA)) pertaining to HHAs that offer on-site client/patient services.
☐	☐	Adheres to accepted professional standards and principles in the provision of services.
☐	☐	Is in current good standing with the State and Federal Tax Departments.
☐	☐	Has a process in place to submit all required information within requested time frames to the Department. This includes monitoring report costs, outcomes service provision and service accessibility and the provision of high quality and responsive services with the capacity to monitor the services delivered by contracted service providers. Provides information on quality assurance, quality improvement and outcome activities to the Department, while protecting the confidentiality of consumers when data is transferred in compliance with state and federal regulations. (3.7d of the Regulation)
☐	☐	Has fiscal management practices that demonstrate cost efficiency and cost controls that minimally include the following: • Ability to meet the payroll in a timely fashion. • Reasonable efforts are made to collect fees from individuals and third-party payors. • Financial records and accounting practices are in accordance with generally accepted accounting practices. • Fire, personal, professional, general liability and board/officer insurance coverage (3.11 of the Regulation)
☐	☐	Has not assigned or transferred any authority or designation. (3.15 of the Regulation)
☐	☐	Has no incidences of financial fraud with any third party payer or vendor, no incidences of inappropriate referral arrangements and compliance with the financial terms and conditions of all state contracts. (3.7d of the Regulation)
☐	☐	HHA complies with the American Disabilities Act (ADA)
☐	☐	Board composition for both not-for-profit and for-profit HHAs meet the intent of the regulation. (6.2 & 6.3 of the Regulation)
☐	☐	HHA complies with the Department of Aging and Independent Living (DAIL), henceforth known as the Department's request for other information, data statistics or schedules. (3.6h of the Regulation)
☐	☐	HHA complies with the Department's request for monitoring data within the requested timeframes and in the format specified. (3.7d of the Regulation)
☐	☐	HHA complies with the Department's request for monitoring the submission of data within the requested timeframes and in the format specified. (3.10 of the Regulation)
☐	☐	HHA provides the Department with sufficient financial detail for the purpose of analyzing data, costs and efficiencies of HHA services paid for by the State. (3.13 of the Regulation)
☐	☐	HHA conducts annual overall self-evaluation including actions taken as a result.(6.9 of the Regulation)

***For any responses marked no please submit detailed explanation as Attachment E.**

SECTION V – ATTESTATION OF COMPLIANCE continued...

Under the pains and penalties of perjury, I hereby swear or affirm that all of the statements, information and certifications in this application are true and accurate to the best of my information and belief.

_____
Signature of Home Health Agency Administrator

_____
(Name Printed)

_____
Signature of Home Health Agency duly authorized Officer of the Corporation

_____
(Name Printed)

_____
Signature of Home Health Agency duly authorized Officer of the Corporation

_____
(Name Printed)

STATE OF VERMONT

COUNTY OF _____

Subscribed and sworn to before me this _____ day of _____, 20_____

_____
Notary Public

_____
(Name Printed)

_____
Commission Expires

A Certificate of Designation issued under this application is not transferable or assignable and will be issued only for the premises and persons named in this application.

LOCAL COMMUNITY SERVICES PLAN

STATE HOME HEALTH DESIGNATION

The local community service plan was last reviewed and revised on _____.
Date

1. Description of the home health care needs within the geographic area for which the agency serves, or wishes to serve.

   a. Demographic profile

   b. Identification of specific HHA needs in the community as identified by providers.

   c. Needs identified by the community members

2. Describe the methods by which your home health agency will meet those needs. (If agency does not expect to meet these needs, give the rationale.)

3. Provide a schedule for the anticipated provision of new or additional services.

4. Describe the resources needed by and available to the home health agency to implement this service plan.

5. What was the process used to obtain public input from the residents of the agency's geographic area and how is that input reflected in the plan?

6. Describe how the plan will be shared with the public.

7. Describe the agency's plan for addressing unforeseen interruption of services.

8. Describe the agency's plan for addressing the need for after hours or weekend services to ensure continuity of service.

(Reference 3.8and 3.9 of state home health designation)

See attached a sample of a Local Community Services Plan with Identified Needs Worksheet.

_____ _____

Signature of Executive Director Date

Green Mountain Home Health Agency
Local Community Services Plans

1. Green Mountain HHA serves a geographic location with a population of 62,000 people. The Agency serves approximately 5% of this population with home health, hospice and Choices for Care.

   The Agency has identified the following home health need(s):

   Expansion of services to Children with Autism.

   The Public has identified the following need(s):

   Support services for children with Autism

2. See attached Local Community Services Plan Identified Needs table for methods.

3. See attached Local Community Services Plan Identified Needs table for schedule.

4. See attached Local Community Services Plan identified needs table for resources.

5. Public input from the residents of geographic location was obtained from input provided by Consumer Advisory Group. The Consumer Advisory Group is composed of XY, TZ and VM. They met in January 2007, April 2007 and June 2007. The group discussed the growing number of children diagnosed with autism. This plan will be evaluated through the Client Satisfaction Survey, quality improvement and monitoring of service utilization.

6. The plan will be shared with the public in the following manner:

   a. distributed to members of the Consumer Advisory Group
   b. distributed to agency staff and board members
   c. distributed upon request
   d. posted on agency website

7. See attached Emergency Management Services Plan for agency's plan on addressing unforeseen interruption of services.

8. The Green Mountain Agency provides skilled nursing, home health aide and physical therapy to patients with medical necessary home care and hospice needs as ordered by the physician. On weekends CFC services are provided as needed and included in clients Plan of Care. A Registered Nurse is on call from 5:00pm to 8:00am each day to respond to clients questions, and visit as indicated. The Green Mountain Agency contracts with Maple Leaf messaging for answering service and beepers.

LOCAL COMMUNITY SERVICES PLAN - IDENTIFIED NEEDS

1. Needs	2. Methods	3. Schedule	4. Resources Needed/Available

LOCAL COMMUNITY SERVICES PLAN - IDENTIFIED NEEDS

1. Needs	2. Methods	3. Schedule	4. Resources Needed/Available
Expansion of Services to Children with Autism	Agency will collaborate with local community mental health, Children's' Development Clinic, CSHN, FIT and local pediatricians to develop interdisciplinary approach to care and management of children with autism.	Through 2008	Pediatric Physical Therapy Occupational Therapy Speech and behavioral interventionist will be hired. Rainbow Philanthropy Grant will provide resource for training and materials
Support Group for Children with Autism	Agency will develop support group for family of children with autism	Spring 2009	Rainbow Philanthropy Grant will provide resources for training and materials. Existing medical social worker will provide family support. Agency will contract with local community mental health for behavioral interventionist.

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

I. Identifying Information

Name of Entity	Provider No.	Telephone No.

Street Address	City State	Zip Code

Mailing Address (if Different)	City State	Zip Code

II. Answer the following questions by checking Yes or No. If any of the questions are answered Yes, list the names and addresses of individuals or corporations under Remarks on page 2. Identify each item number to be continued.

(a) Are there any individuals or organization having a direct or indirect ownership or control interest of 5 percent or more in the institution, organizations, or agency that have been convicted of a criminal offense related to the involvement or such persons, organizations? ☐ Yes ☐ No

(b) Are there any directors, officers, agents, or managing employees of the institution, agency or organization who have ever been convicted of a criminal offense? ☐ Yes ☐ No

III. (a) List names, addresses of individuals, or organizations having direct or indirect ownership or a controlling interest in the entity.

Name Address

_____

_____

(b) Type of Entity ☐ Sole Proprietorship ☐ Partnership ☐ Corporation
☐ Unincorporated Associations ☐ Other (Specify) _____

(c) If the disclosing entity is a corporation, list names and addresses of the Directors.

Name Address

_____

_____

_____

_____

Answer the following questions by checking Yes or No. If you answer Yes to any questions please include detailed explanation and documentation, for example: sales transfer, LLC papers, organizational chart, under Remarks on page 2. Identify each item number to be continued.

IV. (a) Has there been a change in ownership or control within the last year?
If Yes, give date _____ ☐ Yes ☐ No

(b) Do you anticipate any change of ownership or control within the year?
If Yes, when _____ ☐ Yes ☐ No

(c) Do you anticipate filing bankruptcy within the year?
If Yes, when _____ ☐ Yes ☐ No

V. Is this facility operated by a management company, or leased in whole or part by another organization?

If Yes, give date of change in operations _____ □ Yes □ No

VI. Has there been a change in Agency Director, Director of Clinical Services or Medical Director in the last year?
If Yes, give date of change _____ □ Yes □ No

VII. Is this facility chain affiliated? □ Yes □ No

Name _____

Address _____

Whoever knowingly and willfully makes or causes to be made a false statement or representation of this statement, may be prosecuted under applicable federal or state laws. In addition, knowingly and will fully failing to fully and accurately disclose the information requested may result in denial of request to participate or where the entity already participates, a termination of its designation by the state agency.

Name of Authorized Representative (Typed or Printed)	Title
Signature	Date

Remarks

State of _____, County of _____ On this _____ day of _____, 20____,

_____ personally appeared before me and satisfied me that s/he is the person named in and who signed this form. Thereupon s/he acknowledged the signing of the form as her/his act and deed for the uses and purposes expressed in this document.

_____ _____
Printed name of notary Notary signature

_____
Commissions expires