CHANGE OF OWNERSHIP OR CHANGE OF INFORMATION CHECKLIST

TELEHEALTH LONG-TERM CARE DIALYSIS

Accreditation Commission for Health Care (ACHC) requires organizations to provide written notification for any change of ownership (CHOW) or ownership information change of 5 percent or greater. Failure to notify ACHC within 30 days of the change may result in a gap in certification. ACHC will not backdate any certification dates to when the change officially took place.

The following items must be submitted by the proposed new owner to the organization's assigned Account Advisor:

Letter of Attestation

Include the following:

- ☐ Type of change (e.g., acquisition, merger).
- ☐ Details of all changes, such as new management, and a list of new contacts that includes:
  - » Owner, leader, and liaison.
  - » Names, phone numbers, and email addresses.
- ☐ Actual or proposed date of change.
- ☐ Statement that policies and procedures will not change, or statement that policies and procedures are changing (include copies of revised policies and procedures of key standards).
- ☐ Previous and new federal tax ID number and National Provider Identifier (NPI) number, if applicable.
- ☐ New contact(s) including the owner, leader, and liaison, and the phone numbers and email addresses for each.

Documentation

Include the following:

- ☐ Completed "Site Information" form. (See next page).
- ☐ Proof that new owners/managers/organization is not on the Office of Inspector General (OIG) exclusion list.
- ☐ Pre-transaction and post–transaction organizational charts.
- ☐ Resume of new administrator and/or owner and/or management personnel.
- ☐ Business/state licenses, if applicable.

Submitted information will be reviewed, and certification will be determined based on the date of submission.

If a survey is required, the announced regular virtual survey process will be followed. If the organization is found to have substantial deficiencies during the survey, a plan of correction will be required and/or a follow-up Focus Survey may be required.

Contact Name: _____

Contact Phone/Email: _____

SITE INFORMATION

TELEHEALTH LONG-TERM CARE DIALYSIS

Location Information

Branch location? ☐ YES ☐ NO ☐ N/A

Legal Name: _____

DBA Name: _____

Phone #: _____ Fax #: _____

Federal Tax ID #: _____ National Provider Identifier (NPI) #: _____

Medicare Provider #/CCN: _____

Physical Address

Address: _____

City: _____

State: _____ Zip: _____

Location Contact Information

Name: _____

Title: _____

Phone/Email: _____

Name to Display on Certification Certificate

Choose one:

☐ Legal Name ☐ DBA Name ☐ Both Legal and DBA Names

Miscellaneous Information

Hours of Operation: _____

Date Location Established: _____ Number of Employees: _____

Services Provided at This Location

Check all that apply:

☐ Long-Term Care Dialysis Certification

- » Home Dialysis Support Service(s)/Modality(s) provided in LTC facility (SNF/NF):
  - ☐ Home Hemodialysis (HHD) ☐ Peritoneal dialysis (PD)
- » Number of LTC facility(s) (SNF/NF) with established contract/agreements with organization: _____
- » Total patient census, receiving dialysis treatments within LTC facilities (SNF/NF): _____

☐ Telehealth Certification

- » How many admissions have you had in the past 12 months? _____
- » What is your average monthly census? _____