ADMINISTRATOR, OFFICER, DIRECTOR, AGENT, OR MANAGING EMPLOYEE CHANGE FORM

HOME CARE HOME HEALTH HOME INFUSION THERAPY HOSPICE

Type of Change:

☐ Administrator ☐ Alternate Administrator ☐ Officer, Director, Agent, or Managing Employee

☐ Alternate Officer, Director, Agent, or Managing Employee

Effective Date of Change: _____

Company Information:

Legal Name: _____

DBA Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Medicare Provider Number/CCN: _____

Name of Previous Administrator, Officer, Director, Agent, or Managing Employee:

_____

Name and email of New Administrator, Officer, Director, Agent, or Managing Employee:

_____

Indicate if you would like to keep the previous contact as an approved contact on the account:
☐ Yes ☐ No

Attestation Statement:

I, _____ , hereby certify that all of the information on this request is true and correct. I certify the following:

- The individual named above is qualified for the position and is in compliance with all ACHC standards and state and federal rules and regulations.
  - » Orientation has been completed or will be completed within 90 days of hire date, to the organization's policies and procedures, state licensure rules, and Medicare Conditions of Participation.
  - » All required background checks required by ACHC standards and state and federal rules and regulations.
- The state licensing agency and CMS has been informed of the personnel changes for the parent agency.

Signature: _____ Date: _____

ACHC reserves the right to request additional information and proof that CMS and the state licensing agency have been notified of the change.

Please provide ACHC with updated contact information, if this change affects ACHC records:

ACHC Name of main contact: _____

Email address: _____