# OWNERSHIP CHANGE OR OWNERSHIP INFORMATION CHANGE CHECKLIST

HOME CARE

Accreditation Commission for Health Care (ACHC) requires organizations to provide written notification for any change of ownership (CHOW) or ownership information change of 5% or greater. Failure to notify ACHC within 30 days of the change may result in a gap in accreditation.

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

Letter of Attestation, including:

- ☐ Type of change (e.g., acquisition, merger, consolidation, change of ownership [CHOW])
- ☐ Actual or anticipated date of change
- ☐ Statement that policies and procedures will not change, or statement that policies and procedures are changing (include copies of P&Ps for key standards)
- ☐ Old and new Federal Tax ID numbers and National Provider Identifier (NPI) numbers (if applicable)
- ☐ Details of all changes, including new management and/or owners with contact information
  - ☐ Owner, Leader, and Liaison
  - ☐ Names, phone numbers, and email addresses

Documentation, including:

- ☐ Completed Site Information form
- ☐ Proof that new owners/managers/agency are not on the Office of Inspector General's (OIG) exclusion list (http://exclusions.oig.hhs.gov/)
- ☐ Pre-transaction and Post-transaction ownership organizational charts
- ☐ Resume of new administrator and/or owner/DON and/or management personnel
- ☐ Business/State License (if applicable)

Once all required documentation has been submitted, it will be reviewed and an accreditation decision will be made. Upon approval of the submitted documentation, ACHC will issue accreditation based upon the date that all requirements were submitted.

All fees must be paid in full before approval documentation will be issued by ACHC. If it is determined a site survey is necessary, the normal unannounced survey scheduling process will apply and the organization will be charged a survey fee.

If it is determined a survey is not necessary, the organization will be charged based upon the signed accreditation agreement.

If the organization is found to have substantial deficiencies during the on-site survey, a Plan of Correction will be required and/or a follow up Focus Survey may be required.

Contact Name:_____ Contact phone/email:_____

## Location Information:

(Check only one) ☐ Branch Location ☐ Satellite Location ☐ Primary Location

Name to display on Accreditation Certificate (Check only one)

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

Legal Name: _____

DBA Name: _____

Location Phone: _____ Location Fax: _____

## Physical Address:

Address: _____

City: _____ State: _____ ZIP: _____

## Location Contact Information:

Name: _____

Title: _____ Email: _____

## Location Information:

Federal Tax ID #: _____

## Medicare Provider Number/CCN:

CCN for this location: _____

## National Provider Identifier/NPI:

NPI for this location: _____

## Miscellaneous Information:

Hours of Operation: _____

Date Location Established: _____

Number of Employees: _____

## Please select the services that are being provided from this location:

- ☐ Home Care Nursing (HCN)
- ☐ Home Care Aide (HCA)
- ☐ Home Care Companion/Homemaker (HCC)
- ☐ Home Care Occupational Therapy (HCOT)
- ☐ Home Care Physical Therapy (HCPT)
- ☐ Home Care Speech Therapy (HCST)
- ☐ Home Care Social Work (HCSW)
- ☐ Distinction in Palliative Care (PCHC)
- ☐ Distinction in Telehealth (HCTH)