Indiana Department of Health

Eric J. Holcomb
Governor

Lindsay M. Weaver, MD, FACEP
State Health Commissioner

Dear Provider:

Due to recent requests from the Regional Office, and to become more efficient when processing your Change of Ownership (CHOW) applications, the department will require the following information to be submitted in conjunction with each CHOW.

Change of Ownership (CHOW) Requirements

Cover Letter: Each CHOW application must contain an acceptable cover letter. If a CHOW occurs with multiple facilities involved with the same buyer, a separate cover letter and documentation is required for **each** facility. The cover letter should address only one (1) facility. Please ensure that the cover letter is submitted in conjunction with the submission of the CHOW application.
The cover letter should include the following:

- A brief description of the type of transaction
- Projected or actual effective date of the transaction
- Names of the parties involved in the Change of Ownership (CHOW)
- Statement regarding the CMS 855 (whether an 855 has been filed, approved, or will be filed)

Example:
This notice is to confirm that, effective 01/01/2019 a Change of Ownership took place between the buyer, ABC Corporation, EIN 12-345678 and the seller WXY Corporation, d/b/a AAA Homecare. EIN Number 98-765432.

Facility Address: Please list the complete, d/b/a name and address of the seller. Seller's CCN number or license number if applicable.

Other:
Example: *The buyer/seller's CMS 855 application will be/has been filed with the provider's fiscal intermediary. We will notify the department once an approval notice has been received.*

Changes because of the CHOW:

- Name change - Did the name of the agency/clinic change as a result of the CHOW?
- Staff changes (if applicable) - New administrator, medical director, etc.?
- Days/hours or operation changed (if applicable)
- Mailing address changed or added (if applicable)
- Other changes (please describe)

IMPORTANT!

Prior to submission of the cover letter and application, the buyer must submit to the department the following notes. (Notices should be submitted at least 30 days in advance of the transaction taking place):

- A Notice of Intent to Sell letter from the seller - The notice must be on the seller's letterhead and must be signed by the seller or the seller's authorized representative.

- A Notice of Intent to Purchase from the buyer - The notice must be on the buyer's letterhead and must be signed by the buyer or an authorized agent.

Please contact the program coordinator at 317-233-7302 if you have questions regarding this notice.

RURAL HEALTH CLINIC (RHC)
CHANGE OF OWNERSHIP APPLICATION
FOR MEDICARE AND MEDICAID

Dear Applicant:

In accordance with your request, we are enclosing the necessary forms for a Change of Ownership for Rural Health Clinics. Please complete the forms and return them to this office along with a copy of Bill-Of-Sale, Transfer of Assets Agreement or comparable document, document from the Internal Revenue Service that lists the name of corporation and EIN number, and document from the Secretary of State's office that lists name of corporation or d/b/a name (if applicable).

List of forms to be completed and returned:

- Supplementary Information to Federal Application Rural Health Clinic (RHC) (State Form 51054)
- Verification of Clinic Data (Form CMS-29). Instructions for completion are contained on the first page of the form.
- Two (2) copies of the Health Insurance Benefits Agreement (Form CMS-1561 A). Please submit both originals.

NOTE: On the second line of the Health Insurance Benefits Agreement (Form CMS 1561 A) after Social Security Act, enter the entrepreneurial name of the enterprise, followed by the trade name (if different from the entrepreneurial name). Ordinarily, this is the same as the business name used on all official IRS correspondence concerning payroll withholding taxes, such as W-3 or 941 forms.

Example: The ABC Corporation, owner of the Wildwood Health Center, would enter on the agreement "ABC Corporation d/b/a Wildwood Health Center." A partnership of several people might complete the agreement to read "Robert Johnson, Louis Miller, and Paul Allen, partners, Easy Care Health Services." A sole proprietorship would complete the agreement to read "John Smith d/b/a Wembly Walk-in Center."

The person signing the Health Insurance Benefits Agreement must be someone who has the authorization of the owners of the enterprise to enter into this agreement. If the Health Insurance Benefits Agreement is signed by someone other than an officer, director, or partner of the enterprise, then one of the officers, directors or partners of the enterprise as listed on the Medicare General Enrollment Health Care Provider/Supplier Application (Form CMS-855) or Disclosure of Ownership and Control Interest Statement (Form CMS-1513) must give that individual written permission to sign. Please submit a copy of this letter of authorization.

Provider-Based Questionnaire: This form must be completed to determine if the entity meets the criteria as provider based on another Medicare-certified provider for the purpose of Medicare certification and reimbursement.

- If your facility is provider-based to a hospital or a critical access hospital, you must receive **Civil Rights clearance for initial certification and change of ownership. You must complete and submit the Assurance of Compliance form electronically to the Office of Civil Rights and provide the department with proof of your electronic filing.**

Documentation/Information to be submitted:

- A copy of the "Articles of Incorporation" or "Certificate of Assumed Business Name" signed by the Indiana Secretary of State for doing business in Indiana

- A copy of SS-4 form or comparable document from the Internal Revenue Service (IRS) that includes the corporation name and EIN number

- Copies of current valid Indiana licenses on staff - Refer to Supplementary Information to Federal Application Rural Health Clinic (RHC) (State Form 51054)

- A copy of Bill-Of-Sale, Transfer of Assets Agreement, or comparable document. The document must contain the elements listed below:
    - Names of buyer and seller
    - Complete date of transaction (effective date of agreement)
    - Signatures of buyer and seller

Upon receipt of the completed forms and documents, your application will be reviewed and processed.

All copies of the above-listed forms must be completed and have original signatures for the Change of Ownership application to be processed.

If you have any questions, please contact the program coordinator at 317-233-7302.

If you are also a CLIA provider, you must submit written notification of this change to the CLIA program to the attention of Program Director, CLIA, Acute Care 4A, Indiana Department of Health, 2 N. Meridian St., Indianapolis, Indiana 46204-3006.
Please include your CUA provider number in this correspondence.

Please submit your completed RHC CHOW Application Packet to the following address:

Indiana Department of Health
Division of Home and Community-Based Care
2 N. Meridian St.
Indianapolis, IN 46204

Requested Elements for Provider-Based Designation Requests

The purpose of this document is to provide CMS with sufficient information to whether or not the applicant meets the criteria for provider-based designation.

Please submit a cover letter stating you are in compliance with the main criteria used to make

the determination. The cover letter should state the following:

- Main provider's name and provider number
- Main provider's physical address (including county)
- Provider-based entity's name (and current provider number if applicable)
- Entity's physical address (including county)
- Fiscal intermediary of main provider
- That you are in compliance with the Office of Civil Rights requirements
- That you have provided the CCN number of the hospital to which the RHC is provider-based (this information is collected on the CMS 29 Verification of Clinic Data Sheet)
- That you are aware the legal entity holding the provider agreement for the RHC must be the same legal entity holding the hospital's provider agreement and are merely a related subsidiary, the RHC is not eligible for provider-based designation
- That the RHC must have under fifty (50) certified beds

Please complete your description submitted by adding the following certifications:

> I certify that the information provided above and in the attachments is accurate, complete, and current as of this date:
>
> Signature: _____
>
> Printed Name: _____
>
> Title: _____
>
> Date: _____

OMB Control Number 0945-0008
Exp. Date: 04/30/2026

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

ASSURANCE OF COMPLIANCE

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, SECTION 1557 OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT, AND FEDERAL CONSCIENCE AND NONDISCRIMINATION LAWS

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964, as amended (codified at 42 U.S.C. § 2000d *et seq*.), and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin (including limited English proficiency) be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

2. Section 504 of the Rehabilitation Act of 1973, as amended (codified at 29 U.S.C. § 794), and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of their disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

3. Title IX of the Education Amendments of 1972, as amended (codified at 20 U.S.C. § 1681 *et seq*.), and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex (including pregnancy, sexual orientation, and gender identity), be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.

4. The Age Discrimination Act of 1975, as amended (codified at 42 U.S.C. § 6101 *et seq*.), and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

5. Section 1557 of the Patient Protection and Affordable Care Act, as amended (codified at 42 U.S.C. § 18116), and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin (including limited English proficiency), age, disability, or sex (including pregnancy, sexual orientation, and gender identity) be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

As applicable, the Church Amendments, as amended (codified at 42 U.S.C. § 300a-7), the Coats-Snowe Amendment (codified at 42 U.S.C. § 238n), the Weldon Amendment (*e.g.,* Consolidated Appropriations Act, 2022, Pub. L. No.

117-103, Div. H, Title V § 507(d), 136 Stat 49, 496 (Mar. 15, 2022)) as extended by the Continuing Appropriations and Ukraine Supplemental Appropriations Act, 2023, Pub. L. No. 117-180, Div. A, § 101(8) (Sep. 30, 2022); , Section 1553 of the Patient Protection and Affordable Care Act, as amended (codified at 42 U.S.C. § 18113), and Section 1303(b)(4) of the Patient Protection and Affordable Care Act, as amended (codified at 42 U.S.C. § 18023(b)(4)), and 45 C.F.R. Part 88, to the extent that the rights of conscience are protected and associated discrimination and coercion are prohibited, in any program or activity for which the Applicant receives Federal financial assistance. Consistent with applicable court orders, the version of Part 88 in effect as of [October 20, 2022] is found at 76 Fed. Reg. 9968-9977 (Feb. 23, 2011).

The Applicant agrees that compliance with this assurance constitutes a material condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees, and assignees for the period during which such assistance is provided.

If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The person whose signature appears below is authorized to sign this assurance and commit the Applicant to the above provisions.

_____
Date

_____
Signature of Authorized Official

Please mail form to:

U.S. Department of Health & Human Services Office for Civil Rights
200 Independence Ave., S.W. Room 509F Washington, D.C. 20201

_____
Name and Title of Authorized Official (please print or type)

_____
Name of Agency Receiving/Requesting Funding

_____
Street Address

_____
City, State, Zip Code

The Applicant may provide this assurance via the U.S. Department of Health and Human Services' Assurance of Compliance online portal at https://ocrportal.hhs.gov/ocr/aoc/instruction.jsf in lieu of mailing it to the address provided.

INSTRUCTIONS FOR COMPLETING THE VERIFICATION OF CLINIC DATA
RURAL HEALTH CLINIC PROGRAM

The filing of this verification of clinic data is part of the process of obtaining a decision as to whether the rural health clinic conditions for certification are met.

Please do not delay returning the form. Assistance in filling out the form is available from the State agency.

GENERAL INSTRUCTIONS

Please answer all questions as of the current date.

Do not complete the categories identified as State/County or State Region. Return the form to the State agency in the envelope provided; retain a copy for your files. If a return envelope is not provided, the name and address of the State agency may be obtained from your Center for Medicare & Medicaid Services (CMS) regional office at **http://www.cms.hhs.gov/RegionalOffices/**.

Detailed Instructions for Specific Questions

These instructions are designed to clarify certain questions on the form. Instructions are listed in question order for easy reference. No instructions have been given for questions considered self-explanatory.

The Following to be Completed by the Clinic

Question I – Identifying Information
Insert the full name under which the clinic operates. A rural health clinic site is the location at which health services are furnished. If a central organization operates more than one permanent clinic site, a separate Verification of Clinic Data form for each rural health clinic site must be submitted. In these instances, the location of the health clinic site, rather than of the central organization, will determine eligibility to participate. The applicant site must be situated in a rural area which is designated as either an area with a shortage of personal health services or as a health manpower shortage area because of its shortage of primary medical care manpower. If the name of the rural health clinic site does not identify the owner(s), the name and address of the owner(s) are to be inserted in the space provided; otherwise, that space is to be left blank.

Question II – Medical Direction
Insert the name and address of the physician(s) responsible for providing medical direction for the health clinic site.

Question III – Clinic Personnel
(A), (B), and (C) – Personnel are to be described in terms of full-time equivalents. To arrive at full-time equivalents, add the total number of hours worked by personnel in each category in the week ending prior to the week of filing the request and divide by the number of hours in the standard work week (as determined by the clinic policies). If the result is not a whole number, express it as a quarter fraction only (e.g., .00, .25, .50, or .75).

Exclude all trainees and volunteers.

In addition to the physician, a nurse practitioner, physician assistant or a certified nurse-midwife is required for clinic eligibility and must be shown in B and/or C respectively.

(D) – Where other types of personnel are utilized (e.g., technicians, aides, etc.), the discipline, by name is to be indicated in addition to the full-time equivalents.

Under (A), (B), and (C), include in the count only those personnel defined as follows:

Physician – A doctor of medicine or osteopathy legally authorized to practice medicine or surgery in the State in which such function or action is performed. (A physician listed in II, above, should be included in this category for purposes of determining full-time equivalents.)

Nurse practitioner – A registered professional nurse who is currently licensed to practice in the State, who meets the State's requirements governing the qualifications of nurse practitioners and who meets one of the following conditions:

1. Is currently certified as a primary care nurse practitioner by the American Nurses' Association or by the National Board of Pediatric Nurse Practitioners and Associates; or
2. Has satisfactorily completed a formal one academic year educational program that:
   (i) prepares registered nurses to perform an expanded role in the delivery of primary care;
   (ii) includes as least four months (in the aggregate) of classroom instruction and a component of supervised clinical practice; and
   (iii) awards a degree, diploma, or certificate to persons who successfully complete the program; or
3. Has successfully completed a formal educational program for preparing registered nurses to perform an expanded role in the delivery of primary care that does not meet the requirements of paragraph (2) of this section, and has been performing an expanded role in the delivery of primary care for a total of 12 months during the 18-month period immediately preceding the effective date of this subpart.

Physician assistant – A person who meets the applicable State requirements governing the qualifications for assistants to primary care physicians and who meets at least one of the following conditions:

1. Is currently certified by the National Commission on Certification of Physician Assistants to assist primary care physicians; or
2. Has satisfactorily completed a program for preparing physician's assistants that:
   (i) was at least one academic year in length:
   (ii) consisted of supervised clinical practice and at least four months (in the aggregated) of classroom instruction directed toward preparing students to deliver health care; and
   (iii) was accredited by the American Medical Association's Committee on Allied Health Education and Accreditation; or
3. Has satisfactorily completed a formal educational program for preparing physician assistants that does not meet the requirements of paragraph (2) of this section and has been assisting primary care physicians for a total of 12 months during the 18-month period immediately preceding the effective date of this subpart.

Question IV – Type of Control

Identify the rural health clinic in terms of its type of control by checking the appropriate column and row under A, B, C or D. Nonprofit status is based on Internal Revenue Service tax exemption interpretation; i.e., section 501 of the Internal Revenue Code of 1954.

Indicate if the rural health clinic site is or will be a provider-based entity to a hospital or critical access hospital (CAH), in accordance with the provider-based rules located at 42 CFR 413.65. If yes, provide the hospital or CAH's CMS Certification Number (CCN) for the main provider to which the clinic is/will be provider-based.

State Agency Responsibility

A function of the resurvey process is to obtain updated statistical information on organizations providing rural health clinic services. At the time of resurvey, the surveyor will bring this form and request that a representative of the organization complete, sign, and date it by the completion of the onsite visit. The surveyor will review the form for completeness and accuracy and initial after the signature of the organization's representative. On all resurveys insert the clinic's assigned CCN.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Form Approved
OMB N0. 0938-0074

VERIFICATION OF CLINIC DATA – RURAL HEALTH CLINIC PROGRAM

Medicare program must complete this form and return it to the State agency that is handling the certification process. If a return envelope is not provided, the name and address of the State agency may be obtained from the Center for Medicare & Medicaid Services (CMS) regional office at **http://www.cms.hhs.gov/RegionalOffices/**.
This form is also to be completed when the State agency surveys a participating RHC.

CMS CERTIFICATION NO. (RH1)
STATE/COUNTY (RH2)
STATE REGION (RH3)

I. **IDENTIFYING INFORMATION** (TO BE COMPLETED FOR EACH CLINIC SITE)	NAME OF CLINIC	STREET ADDRESS	
	CITY, COUNTY AND STATE	ZIP CODE	TELEPHONE NO. *(Including Area Code)* (RH4)
NAME AND ADDRESS OF CLINIC OWNER(S) (RH5)			
II. **MEDICAL DIRECTION**			

III. **CLINIC PERSONNEL** (FULL TIME EQUIVALENTS)	(A) PHYSICIAN (RH6)	(B) NURSE PRACTITIONER (RH7)	(C) PHYSICIAN ASSISTANT (RH8)	(D) OTHER (RH9)

IV. **TYPE OF CONTROL** (check one)		A. INDIVIDUAL	B. CORPORATION	C. PARTNERSHIP	D. GOVERNMENT
	1. PROFIT	◯	◯	◯	STATE 3. ◯ LOCAL 4. ◯ FEDERAL 5. ◯
	2. NON- PROFIT	◯	◯	◯	

Is the RHC a provider-based entity to a hospital or critical access hospital (CAH)? Yes ◯ No ◯ (RH11)
(check one)

(RH10) If yes, please indicate the CMS Certification Number of the hospital/CAH _____ (RH12)

I certify that this information is true, correct, and complete. I agree, if approval is granted, that all services rendered by the clinic shall be in conformity with Federal, State, and local laws. I further understand that a violation of such laws will constitute grounds for withdrawal of approval under the regulations. If any information within this application (or attachments thereto) constitutes a trade secret or privileged or confidential information (as such terms are interpreted under the Freedom of Information Act and applicable case law), or is of a highly sensitive personal nature such that disclosure would constitute a clearly unwarranted invasion of the personal privacy of one or more persons, then such information will be protected from release by CMS under 5 U.S.C. §§ 552(b)(4) and/or (b)(6), respectively.

SIGNATURE OF AUTHORIZED OFFICIAL	TITLE	DATE (RH13)

HEALTH INSURANCE BENEFITS AGREEMENT

(Agreement with Rural Health Clinic Pursuant to
Section 1861(aa)(2)(K)(ii) of the Social Security Act)
(CMS-1561A)

For the purpose of establishing eligibility for payment under Title XVIII of the Social Security Act,

hereafter referred to as the Rural Health Clinic, hereby agrees:

(A) To maintain compliance with the conditions for certification set forth in part 491 of chapter IV, title 42 of the Code of Federal Regulations, and to report promptly to the Centers for Medicare & Medicaid Services any failure to do so;

(B) Not to charge the beneficiary or any other person for items and services for which the beneficiary is entitled to have payment made under the provisions of part 405 of chapter IV, title 42 of the Code of Federal Regulations (or for which the beneficiary would have been entitled if the Rural Health Clinic had filed a request for payment in accordance with §410.165 of chapter IV), except for any deductible or coinsurance amounts for which the beneficiary is liable under §405.2410;

(C) To refund as promptly as possible any money incorrectly collected from a beneficiary or from someone on his or her behalf;

(D) To accept beneficiaries for care and treatment without limitations, except as it may impose on all other persons;

(E) To accept any additional provisions that the Secretary finds necessary or desirable for the efficient and effective administration of the Medicare program.

This agreement, upon submission by the Rural Health Clinic and upon acceptance for filing by the Secretary of Health and Human Services, shall be binding on the Rural Health Clinic and the Secretary. The agreement may be terminated by either party in accordance with regulations. In the event of termination, payment will not be available for Rural Health Clinic services furnished on or after the effective date of termination.

This agreement shall become effective on the date specified below by the Secretary or the Secretary's delegate, and shall remain in effect unless terminated.

In the event of a transfer of ownership, the agreement is automatically assigned to the new owner subject to the conditions specified in this agreement and 42 CFR 489, to include existing plans of correction and the duration of this agreement, if the agreement is time limited.

ATTENTION: Read the following provision of Federal law carefully before signing.

Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or make any false, fictitious or fraudulent statement or representation, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement, or entry, shall be fined not more than $10,000 or imprisoned not more than 5 years or both (18 U.S.C. section 1001).

Accepted for Rural Health Clinic By:

Signature	Title
Printed Name	**Date**

Accepted for Secretary of Health & Human Services By:

Signature	Title
Printed Name	**Date**

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-0832 (Expires 01/31/2027)**. This is a **mandatory** information collection. The time required to complete this information collection is estimated to average 1 hour per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

****CMS Disclosure****

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact CMS at **QSOG_RHC-FQHC@cms.hhs.gov**.

SUPPLEMENTARY INFORMATION TO FEDERAL APPLICATION
RURAL HEALTH CLINIC (RHC)

State Form 51054 (R/4-05)
INDIANA STATE DEPARTMENT OF HEALTH - DIVISION OF ACUTE CARE

Division of Acute Care Use Only

Date Received_____ **Date Approved**_____

THE APPLICTION MUST BE COMPLETED IN ITS ENTIRETY IN ORDER FOR ISDH TO PROCESS THE APPLICATION

Please Type or Print Legibly

SECTION I - TYPE OF APPLICATON

Application *(check appropriate item)*

☐ **Change of Ownership** ***(Anticipated date of Sale/Purchase/Lease)***_____ ☐ **New Facility** ☐ **Other**

Submit a dated and signed copy of the bill of sale, lease or other document of transfer

SECTION II - IDENTIFYING INFORMATION

A. Practice Location *(name of facility-practice location)d/b/a of direct owner (entity)*

If the d/b/a is different from the direct owner submit Articles of Incorporation from the Office of the Secretary of State listing the d/b/a. The d/b/a should be registered with the Office of the Secretary of State and appear on the Articles of Incorporation submitted to ISDH with the application.

Name of Agency		
Street Address		P.O. Box
City	County	Zip Code +4
Telephone Number ( )	Fax Number ( )	Facility's office hours *(i.e. 8:00 a.m. – 4:00 p.m. Monday - Friday)*

B. Mailing Address *(if different from practice location)*

Street Address		P.O. Box
City	State	Zip Code +4

C. Ownership Information *(direct owner (entity) of the rural health clinic (d/b/a)*

The owner/entity as registered with the Office of Secretary of State and appears on the Articles of Incorporation form submitted to ISDH. Submit Articles of Incorporation from the Office of Secretary of State along with a W9 or other comparable document from the Internal Revenue Service that reflects your corporation name, d/b/a if applicable and EIN number.

Ownership *(Operator(s) of the facility-practice location) The owner-applicant entity as registered with the secretary of state*			
Street Address			P.O. Box
City	State		Zip Code+4
Telephone Number ( )	Fax Number ( )	EIN Number	Fiscal Year End Date *(mm/dd)*

D. Provider Based

Is this facility a provider based facility? ☐ Yes ☐ No *(Is yes, provide provider Medicare number)*

If yes, please submit the documentation requested on the enclosed **Provider Based Designation** letter.

SECTION III - UDERSERVED AREA

Is the clinic designated as in underserved area? ☐ Yes ☐ No

SECTION IV – STAFFING AND STAFFING RESPONSIBILITIES

A. Administrator (office manager)

Name *(enter full name)*

B. Physician/MD

A physician is present for sufficient periods of time, at least once in every 2 week period *(except in extraordinary circumstances*), to provide the medical direction, medical care services, consultation and supervision and is available through direct telecommunication for consultation, assistance with medical emergencies, or patient referral. **Refer SOM: 491.8 Staffing and Staff Responsibilities.**

Name *(enter full name)* ***Submit a current copy of the physician's Indiana license (billfold size)***	Days/hours available *(i.e, Monday 2 hrs, Tuesday 4 hrs)*

Responsibilities

C. Physician Assistant/Nurse Practitioner/Certified Nurse Midwife

A nurse practitioner or a physician assistant must be available to furnish patient care services at least 60 percent of the time the clinic operates. **Refer SOM: 491.8 Staffing and Staff Responsibilities.**

A physician assistant or nurse practitioner in addition to the physician is required for clinic eligibility. *(select appropriate box)*

☐ Physician Assistant ☐ Nurse Practitioner ☐ Certified Nurse Midwife

Submit a current copy of the physician assistant, nurse practitioner and/or certified nurse midwife Indiana license (billfold size).

Name of Physician Assistant *(enter full name)*	Days/hours available *(i.e, Monday 2 hrs, Tuesday 4 hrs)*

Responsibilities

Name of Nurse Practitioner *(enter full name)*	Days/hours available *(i.e, Monday 2 hrs, Tuesday 4 hrs)*

Responsibilities

Name of Certified Nurse Midwife *(enter full name)*	Days/hours available *(i.e, Monday 2 hrs, Tuesday 4 hrs)*

Responsibilities

SECTON V - OWNERSHIP OF APPLICANT ENTITY

A. Ownership Information *(officers/directors/managing agents/managing employees of the rural health clinic)*

List all individuals *(persons)* associated with the applicant entity and indicate the individual's title *(i.e. officer, director, member, partner, president, vice president, secretary, etc)*. If the applicant is a partnership, list the name and title of each partner or the name and title of all individuals associated with each entity that forms the partnership. If the applicant is a Limited Liability Company, list the name and title for all individuals associated with each member entity that forms the Limited Liability Company. *(use additional sheet if necessary)*

Name	Title	Business Address (street address/city/state/zip)

B. Type of Change in Ownership *(applicable for change of ownership only – do not complete if initial application)*

☐ Asset Purchase Agreement ☐ Assignment of Interest ☐ Lease

☐ Merger ☐ New Partnership ☐ Sale

☐ Termination of Lease ☐ Transfer of Asset Agreement ☐ Other _____

C. Type of Entity *(Complete for initial and change of ownership applications)*

For Profit

☐ Individual
☐ Partnership
☐ Corporation
☐ Limited Liability Company
☐ Sole Proprietorship
☐ Other *(specify)* _____

NonProfit

☐ Church Related
☐ Individual
☐ Partnership
☐ Corporation
☐ Limited Liability Company
☐ Other *(specify)* _____

Government

☐ State
☐ County
☐ City
☐ City/County
☐ Hospital District
☐ Federal
☐ Other *(specify)* _____

If a Limited Partnership, submit a copy of the "Application For Registration" and Certificate of Registration" signed by the Indiana Secretary of State.

If a Corporation, submit a copy of the "Articles of Incorporation" and "Certificate of Incorporation" signed by the Indiana Secretary of State. If a foreign Corporation, submit a copy of the "Certificate to do Business in the State of Indiana" signed the Indiana Secretary of State.

If a Limited Liability Company, submit a copy of the "Articles of Organization" and the "Certificate of Organization" signed by the Indiana Secretary of State.

If the "doing business as" (dba) name is different from the corporation's *(direct owner)* name submit "Articles of Incorporation" signed by the Indiana Secretary of State that list the d/b/a name.

Submit a *W9 or other comparable document from the Internal Revenue Service that reflects your corporation name, d/b/a if applicable and EIN number.*

Applicant's signature or signature of authorized agent should appear below	
Signature of Authorized Representative	
Title	**Date**

NOTIFY THE INDIANA STATE DEPARTMENT OF HEALTH IN WRITING OF ANY CHANGES IN YOUR STAFF AND/OR SERVICES

SUBMIT CHANGES TO:

INDIANA STATE DEPARTMENT OF HEALTH
ACUTE CARE DIVISION
PHNSS-PROGRAM DIRECTOR
2 NORTH MERIDIAN STREET
SECTION 4A 07
INDIANAPOLIS IN 46204

STAFFING AND STAFF RESPONSIBILITIES
(Type or print legibly)

Physician Information	
Physician's Name	
Days/Hours Available *(i.e .Monday 2 hrs, Tuesday 4 hrs etc)*	
Responsibilities	
Signature of Physician	Date
Signature of Authorized Representative	Date

Physician Assistant, Nurse Practitioner or Midwife Information **❑ Physician Assistant □ Nurse Practitioner □ Midwife** **(Please mark accordingly)**	
Name of Physician Assistant, Nurse Practitioner or Midwife	
Days/Hours Available *(i.e. Monday 2 hrs, Tuesday 4hrs, etc)*	
Responsibilities	
Signature of Physician Assistant, Nurse Practitioner or Midwife	Date
Signature of Authorized Representative	Date