NOTICE
THIS APPLICATION WAS REVISED IN DECEMBER 2019
PLEASE READ CAREFULLY

Change of Ownership License Application
To Operate an End Stage Renal Disease Treatment Facility

Regulations affecting the application for licensure of End Stage Renal Disease Treatment Facilities can be found by clicking the Rules tab or link on the applications page.

The application should be submitted to this office at least 30 days prior to the change of ownership. In addition to the information requested within the application, the following must also be submitted:

1. A completed license application and $240 application fee. Application fees are not refundable.

2. Organizational documents such as Articles of Incorporation, Articles of Organization, Partnership Agreement, LLC Agreement, or Statement of Sole Proprietorship under which the facility will operate. Corporations, Limited Partnerships and Limited Liability Companies must provide approved documentation from the Office of the Secretary of State to conduct business in the State of Alabama.

3. A copy of the Certificate of Existence (for domestic entities) or the certificate of registration (for foreign entities issued by the Alabama Secretary of State), as proof of its authority to transact business in the state of Alabama.

4. Approval of the change of ownership by the State Health Planning and Development Agency.

5. A draft copy of the document consummating the transfer of ownership, such as a lease, sales, or management agreement. An unsigned copy or draft is acceptable when submitting the application.

6. A signed copy of the document consummating the transfer of ownership, such as a lease, sales, or management agreement **must** be submitted prior to the issuance of a license certificate.

7. A copy of the certificate of Completion. The proposed physical site (existing or new construction) must comply with certain requirements and be approved by the Technical Services Unit of this agency. Additional information can be obtained in the facilities rules section of this website or from the Technical Services Unit at **(334) 206-5177.**

An on-site survey by the survey or regulatory staff may be required before the license can be granted.

NOTE Contact the department for ways to enhance the application to shorten the review time. The earliest date a license can be granted is the first day all documents and surveys have been approved by the department.

For state licensure purposes, a change of ownership is not effective until a new license certificate has been issued.

Please note: It is a violation of state law to operate an end stage renal disease treatment facility before you are granted a license from this agency. If you have questions regarding your application, please call (334) 206-5175.

ADDITIONAL INFORMATION
END STAGE RENAL DISEASE TREATMENT FACILITY

Item 1, Applicant. The applicant is the individual, partnership, corporation or other entity who will be the governing authority of the facility and to whom the license will be granted **(not the facility name or the individual completing the application, unless the applicant is an individual)**. The name entered in this section must be exactly as printed on the legal document establishing the entity. A copy of the legal document must accompany this application. Entities established in a state other than Alabama must register to conduct business in Alabama with the Secretary of State's Office. A copy of the registration must also accompany this application. If the facility is leased, the lessee should be indicated as the applicant. The lessee may be an individual, partnership, corporation, or other entity. **NOTE - The applicant must be the operator of the facility, the entity that hires or terminates the administrator, determines patient care issues, makes payment for facility obligations, etc.**

Item 6, Total Number of Dialysis Stations. Total number of stations the facility will operate, including home training and isolation stations. This number cannot exceed the number of stations issued on the Certificate of Need. Provide a breakdown of the total number of stations in item 12. The sum of item 12 should equal the total number of dialysis stations listed in item 6.

Item 7, Facility Name. The information provided on this line will be entered in the Provider Services Directory and the facility will be referred to by this name exactly as entered on this application. This name should be the same as on advertisements, facility letterhead, signs in front of the facility and certification information. This name must be unique; that is, it may not be the same as the name of any other licensed facility in Alabama, nor may it be so similar to the name of any other licensed facility that, in the judgment of ADPH staff, there could be any confusion to the public. Governing authorities operating more than one facility may give the facilities they operate similar, but not identical names. The name may be abbreviated if the abbreviation is also used on advertisements, facility letterhead, signs in front of the facility and certification information.

Item 9, Facility's Mailing Address. The facility mailing address, street address or post office box must be within the same postal service area as the facility's physical location.

Item 19, Attestation of Responsible Person. A company officer, board member, administrator or other responsible person must sign the application and make the attestation.

Application Fee. The application fee for an end stage renal disease treatment facility is $240. Application fees are not refundable. Make a check or money order payable to the Alabama Department of Public Health.

Attachments. Each attachment must be referenced a specific applicable item. For example, attachment to item 14 d should be referenced in the document and labeled as such.

Printing of License Certificates - License certificates are now available on-line. When a license is granted or renewed the license certificate can be printed on-line at https://ph.state.al.us/FacilityCertificatePrint. A facility ID and pin number will be provided and must be used to print license certificates.

APPLICATION FEE	FOR DEPARTMENTAL USE ONLY
APPLICATION FEES ARE NOT REFUNDABLE. The application fee is $240. MAKE CHECK OR MONEY ORDER PAYABLE TO: ALABAMA DEPARTMENT OF PUBLIC HEALTH	Classification _____ # of Stations _____ Application Fee _____ Check # _____ Facility ID # _____

(Revised 12/19)

STATE OF ALABAMA
DEPARTMENT OF PUBLIC HEALTH
DIVISION OF PROVIDER SERVICES
P.O. BOX 303017 (MAILING ADDRESS)
MONTGOMERY, ALABAMA 36130-3017
THE RSA TOWER, SUITE 710, 201 MONROE STREET, MONTGOMERY, AL 36104
(PHYSICAL LOCATION)

CHANGE OF OWNERSHIP APPLICATION TO OPERATE AN END STAGE RENAL DISEASE TREATMENT AND TRANSPLANT FACILITY, INCLUDING FREE STANDING HEMODIALYSIS UNITS

1. _____
Applicant
(see instructions on page 2)

2. _____
Applicant Address

3. _____
City State Zip Code

4. _____
Applicant Telephone Number

5. _____
Facility Administrator

_____
Facility Administrator' Email Address

6. _____
Total Number of Dialysis Stations
(see instructions on page 2)

7. _____
Facility Name
(see instructions on page 2)

8. _____
Facility Physical Address

9. _____
Facility Mailing Address
(see instructions on page 2)

10. _____
City Zip Code County

11. _____
Facility Telephone Number

12. _____/_____/_____
Hemodialysis Peritoneal Home Training
(Breakdown of total number of dialysis stations)

Modality Change_____/(**Attach an explanation**

13. This application is to apply for (check one):

a. Change of ownership ☐ b. Change of ownership and name change ☐ The facility is currently licensed as _____
(Facility Name) (Facility ID number)

14. Applicant Information

a. Applicant is a (check one):

Individual	☐	Nonprofit Corporation	☐	City	☐
Partnership	☐	Hospital Authority	☐	County	☐
Corporation	☐	State	☐	Joint City County	☐
Limited Liability Company	☐	Other: ___ _____	☐		

b. List all the applicant's board members and officers (attach additional paper if necessary).

_____ _____

_____ _____

c. List the name(s) of any person or business entity that has 5% or more ownership interest in the applicant (attach additional paper if necessary). Also, attach a diagram depicting the organizational structure.

_____ _____

_____ _____

d. Does this applicant or any of its owners listed in item "c" operate any other health care facility in Alabama or in any other state? YES ☐ NO ☐ If yes, attach a list including the type(s) of facility(s), name(s), address(s), and owner(s).

e. Have any of the facilities listed in item "d" had any adverse licensure action taken against them or been subject to exclusion from the Medicare or Medicaid Reimbursement Programs? YES ☐ NO ☐ If yes, attach an explanation.

f. Have the applicant, officers or principals ever had a license application denied by this or any other state? YES ☐ NO ☐ If yes, attach an explanation.

15. Has the facility administrator listed in item "5" of this application:

a. ever been convicted of a crime? YES ☐ NO ☐

b. ever been found guilty of abusing another individual? YES ☐ NO ☐

c. ever had adverse action taken against a professional license, for example, nursing home administrator license, attorney license, nurse license, physician license? YES ☐ NO ☐

d. ever been excluded from participation in Medicare or Medicaid Reimbursement Program? YES ☐ NO ☐

If a, b, c, or d are yes, attach an explanation for each affirmative answer.

16. Provide the name, phone number, and email address of a knowledgeable person who can supply details about this application.

Name (print) _____

Phone _____

Email _____

17. Are there any outstanding citations of deficiency, either Federal or State, that have not been corrected? YES ☐ NO ☐

If yes, has the plan of correction for these deficiencies been accepted by the Division of Health Care Facilities? YES ☐ NO ☐

Note: The new licensee will be responsible for correcting all outstanding deficiencies and may be subject to sanctions imposed for past or present deficiencies, including payment of any uncollected civil monetary penalties.

18. Administrator Signature:

I declare, under penalty of perjury, that I have not operated or allowed to be operated this facility, or any other facility, without a license. I agree to operate this facility according to the Rules of the Alabama State Board of Health.

_____ _____

Printed Name Signature

_____

Date

NOTARIZED:

Sworn to and subscribed before me this _____

day of _____ 20_____.

_____

(Notary Public)

19. Attestation of Responsible Person:

I declare, under penalty of perjury, that I have personal knowledge about the statements made in this application and certify that all statements are true and correct. To the best of my knowledge, neither the applicant nor any of the principals, including myself, the owners, and the administrator, have operated or allowed to be operated this facility, or any other facility, without a license. I certify that I am authorized to make this representation on behalf of the applicant.

Signature: _____ Printed Name: _____

Title/Position: _____ Date:_____

NOTARIZED:

Sworn to and subscribed before me this _____

day of _____ 20_____.

_____

(Notary Public)

20. Current Licensee Signature:

The current licensee of this facility concurs with this change of ownership and recommends that this change of ownership application be granted. I certify that I am authorized to make this representation on behalf of the current licensee.

_____	_____
Name of Current Licensed Entity	Signature
_____	_____
Date	Printed Name

NOTARIZED:

Sworn to and subscribed before me this _____

day of _____ 20_____.

_____

(Notary Public)

MANDATORY ACKNOWLEDGMENT NOTICE

Pursuant to *Alabama Code* section 30-3-194, every applicant seeking from a state agency a license, certificate, permit, or authorization to engage in a profession, occupation, or commercial activity, must provide the social security number of the person signing the application, whether as an individual or on behalf of an entity or corporation. Failure to provide this social security number will result in the denial of the application.

Print or Type Name of Person Signing Application: _____

Social Security Number of Person Signing Application: _____

Print or Type the Facility Name: _____

THIS PAGE **NOT** FOR PUBLIC RECORD