DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH CARE FACILITY
LICENSURE & CERTIFICATION
67 Forest Street
Marlborough, MA 01752

COMMON FORM: INITIAL LICENSURE/SUITABILITY NOTICE OF INTENT TO ACQUIRE

Submit this form and all required attachments and supporting documentation when making an application for initial licensure, suitability determination or change in ownership. Submit your completed application with attachments to:

Licensure Coordinator
DPH, Division of Health Care Facility Licensure and Certification
67 Forest Street
Marlborough, MA 01752

A. APPLICANT INFORMATION:

1. _____
Facility/Agency/Program Name (name by which you will do business)

2. _____
Licensee's Name (Individual Owner, Partnership, Limited Partnership, Corporation Name)

3. _____
Facility/Agency/Program Address (Street, City/Town, ZIP)

4. _____ 5. _____
Facility/Agency/Program Telephone Number Facility/Agency/Program Fax Number

6. _____
Administrator's Name

_____ Clinics and hospice: Completed DPH/DHCFLC CORI form attached. (If not, explain in attachment.)

7. _____
Applicant Point of Contact (name of person DPH should contact regarding this application)

8. _____ 9. _____
Point of Contact's Telephone Number Point of Contact's Email Address

10. Provider Type:

	Adult Day Health		*Hospice*
	Clinic – All except LSC or ASC		*Hospital*
	Clinic – Ambulatory Surgery Center		*Nursing Home*
	Clinic – Limited Services		*Rest Home*
	ESRD		

11. Application Type:

____ Initial licensure.

____ Change of ownership (four digit DPH license number: | | | | |)

___ **Copy of purchase and sale agreement, or other documentation of pending change of ownership attached.**

12. Will number of beds, program capacity, or any services offered change:

No ☐ **Yes** ☐ **(attach explanation)**

13. Date on which you anticipate opening (initial licensure) or for change of ownership to become effective: _____

14. **HOSPITAL, CLINIC AND HOSPICE ONLY**: Are there satellite sites, branches or inpatient hospice facilities associated with this application?

___ No – proceed to Part B.

___ **Yes – attach the following:**

___ **List of all existing/proposed satellite sites.**
___ **New Satellite Location Application for each site.**
___ **Programmatic Specific Licensure Application for each new site.**

B. REQUIRED PRE-APPROVALS:

NOTE: The Department is not able to find an applicant suitable unless all required approvals for licensure have been obtained.

1. Determination of Need (See DPH Determination of Need website: https://www.mass.gov/determination-of-need-don)

___ **Copy of Approval Letter Attached**

___ Not Applicable – Reason: _____

2. Plan Approval (See DPH Plan Review website: https://www.mass.gov/guides/plan-review-for-health-care-facilities):

___ **Copy of Approval Letter Attached**

___ Not Applicable – Reason: _____

3. Fire Certificate from Local Fire Department:

___ **Copy Attached For Buildings Occupied By Residents/Patients/Participants**

___ **To be submitted (new construction only - DPH will not book for survey until received)**

___ Not Applicable – Reason: _____

4. DPH, Department of Public Safety or Local Occupancy Certificate:

Provider Type:	Inspection Certificate Required:
• Hospital with inpatient beds • Rest Home	Department of Public Safety (DPS) Certificate of Inspection
• Adult Day Health Program • Clinic (including ambulatory surgical center) • End Stage Renal Dialysis Center • Hospital satellite/no inpatient beds	Local Certificate of Occupancy
• Nursing Home • Inpatient Hospice Service	Division of Health Care Facility Licensure and Certification Fire Inspection Certificate

___ **Copy Attached For Each Building Occupied By Residents/Patients**

___ **To be submitted (new construction only - DPH will not book for survey until received)**

___ Not Applicable – Reason: _____

5. Application fee: **Attach check, payable to "Commonwealth of Massachusetts" for the appropriate fee.** (See https://www.mass.gov/info-details/health-care-facility-licensure-fee-schedule)

Check number: _____ in the amount of: _____ attached.

C. OWNERSHIP INFORMATION

1. Applicant's Ownership Structure – *Please check one:*

___ Sole Proprietorship (Individual)

___ Partnership

___ Limited Partnership

___ Charitable (non-profit) Corporation

___ Corporation (for profit)

___ Limited Liability Corporation

___ Other (please specify): _____

2. If the applicant is a partnership, limited partnership or corporation of any nature, please provide the nine digit identification number as registered with the Massachusetts Secretary of State's office:

(Nine digit Massachusetts Secretary of State number)

3. If a corporation, please list the officers and directors (or board of trustees if non-profit) of the corporation:

a. _____ b. _____
Name #1 Title

c. _____
Address (Street, City/Town, State, ZIP)

☐ **Completed DPH/DHCFLC CORI form attached.** (If not, explain in attachment.)

d. _____ e. _____
Name #2 Title

f. _____
Address (Street, City/Town, State, ZIP)

☐ **Completed DPH/DHCFLC CORI form attached.** (If not, explain in attachment.)

g. _____ h. _____
Name #3 Title

i. _____
Address (Street, City/Town, State, ZIP)

☐ **Completed DPH/DHCFLC CORI form attached.** (If not, explain in attachment.)

j. _____ k. _____
Name #4 Title

l. _____
Address (Street, City/Town, State, ZIP)

☐ **Completed DPH/DHCFLC CORI form attached.** (If not, explain in attachment.)

m. _____ n. _____
Name #5 Title

o. _____
Address (Street, City/Town, State, ZIP)

☐ **Completed DPH/DHCFLC CORI form attached.** (If not, explain in attachment.)

(List attached of any other officers or directors. ☐ Yes; ☐ No)

4. Owners/Members Name(s) – *Please provide information on any:*
   - *Individuals (both in an individual capacity or through another entity) with a 5% or more ownership interest; or,*
   - *Any entity (corporation, LLC, etc.) with a 5% or more ownership; or,*
   - *Members of a non-profit corporation.*

a. _____ b. _____
Name #1 Ownership Interest (% owned)

c. _____
Address (Street, City/Town, State, ZIP)

☐ **Completed DPH/DHCFLC CORI form attached**. (If not, explain in attachment.)

d. _____ e. _____
Name #2 Ownership Interest (% owned)

f. _____
Address (Street, City/Town, State, ZIP)

☐ **Completed DPH/DHCFLC CORI form attached.** (If not, explain in attachment.)

g. _____ h. _____
Name #3 Ownership Interest (% owned)

i. _____
Address (Street, City/Town, State, ZIP)

☐ **Completed DPH/DHCFLC CORI form attached.** (If not, explain in attachment.)

j. _____ k. _____
Name #4 Ownership Interest (% owned)

l. _____
Address (Street, City/Town, State, ZIP)

☐ **Completed DPH/DHCFLC CORI form attached.** (If not, explain in attachment.)

m. _____ n. _____
Name #5 Title

o. _____
Address (Street, City/Town, State, ZIP)

☐ **Completed DPH/DHCFLC CORI form attached.** (If not, explain in attachment.)

(List attached of any other additional 5% or greater owners. ☐ Yes; ☐ No)

D. REAL PROPERTY OWNERSHIP INFORMATION

1. Is the applicant the owner of the real property on which any facility used to house residents or treat patients is located or, if not the owner of the real property on which any facility used to house residents or treat patients is located, has the applicant entered into a lease agreement for at least one year for those premises?

___ Yes – Proceed to Question D.2.

___ No – **Attach detailed explanation of applicant's authority to occupy the premises for the purposes which a license is being sought.**

2. Has the applicant entered into any leasing, financial or other agreement in which the license would be subject to sale, assignment or other transfer, either voluntarily or involuntary, as a result of default or operation of the agreement:

___ No – Nursing and rest homes, proceed to D.3, all others, proceed to Part E.

___ Yes – The Department may not approve a license application in which the applicant has entered into an agreement that would subject the license to transfer without the review and approval of the Department.

3. **NURSING AND REST HOMES ONLY**: Real Property Owners– Please provide information on all individuals *(both in an individual capacity or through another entity)* with a 5% or more ownership interest in the real property.

a. _____ b. _____
Name #1 Ownership Interest (% owned)

c. _____
Address (Street, City/Town, State, ZIP)

d. _____ e. _____
Name #2 Ownership Interest (% owned)

f. _____
Address (Street, City/Town, State, ZIP)

g. _____ h. _____
Name #3 Ownership Interest (% owned)

i. _____
Address (Street, City/Town, State, ZIP)

(Attach list of any additional 5% or greater owners.)

E. COMPLIANCE HISTORY:

1. Are any of the corporate officers, directors, or owners listed in parts C.3 and C.4 or real property owners listed in part D.3 currently or previously the owner or operator of any other healthcare facilities (or long-term care facility only for nursing home/rest home applicants; acute care hospitals only for acute care hospital applicants) in Massachusetts or any other jurisdiction?

___ Yes – **Chart attached listing all healthcare facilities currently or in the last ten years owned or operated by each individual or corporation listed as an owner, officer or director (parts C.3 and C.4) or real property owner (part D.3) on the Suitability Application with**:

- Separate page(s) for each state;
- Facilities separated by type of facility (hospital, clinic, etc.);
- Name of individual or corporation and how affiliated;
- Facility name and address;
- Medicare and Medicaid provider numbers;
- Number of licensed beds, if applicable;
- When the facility became associated with the applicant; and,
- If the applicant is only the manager please indicate this.

___ No – **Resume of each owner, officer, director and real property owner is attached.**

2. Have any of the corporate officers, directors, or owners listed in parts C.3 and C.4 or real property owners listed in part D.3 previously owned or operated any healthcare facility (or long-term care facility only for nursing home/rest home applicants; acute care hospitals only for acute care hospital applicants) in Massachusetts or any other jurisdiction, and, either individually or severally:

(1) Been deemed unsuitable to own or operate a healthcare facility or program; or,

(2) Had a license and/or Medicare or Medicaid certification denied or revoked; or,

(3) Entered into a settlement agreement to avoid loss of license or Medicare or Medicaid certification; or,

(4) Personally been the subject of a valid finding of abuse, neglect or misappropriation against a home health, homemaker or hospice patient; long-term care resident; or an elderly (as defined under M.G.L. c. 19A); or disabled person (as defined under M.G.L. c. 19C); or,

(5) Had a professional license revoked, or been subject to disciplinary action by a board of professional licensure?

____ No – Proceed to Part F.

____ Yes – **Complete and attach Suitability Application Disclosure Form**.

F. CRIMINAL HISTORY:

In the last ten years have any of the corporate officers, directors, or owners listed in parts C.3 and C.4 or real property owners listed in part D.3, either individually or severally, been convicted; entered a plea of guilty; entered a plea of no contest; or entered into a settlement such as a continuation without a finding in order to avoid a criminal conviction, of any criminal charge relating to:

(1) Medicare or Medicaid fraud; or,

(2) Abuse, neglect or misappropriation involving a home health, homemaker or hospice patient; long term care resident; an elderly person (as defined under M.G.L. c. 19A); or a disabled person (as defined under M.G.L. c. 19C).

____ No – Proceed to Part G.

____ Yes – **Complete and attach Suitability Application Disclosure Form**.

G. FINANCIAL CAPACITY:

1. Does the applicant have sufficient financial capacity, as evidenced by present resources, to provide ongoing care and services in compliance with state law and regulation?

____ Yes – Proceed to Question G.2.

____ No – **Complete and attach Suitability Application Disclosure Form**.

2. Have any of the corporate officers, directors, or owners listed in parts C.3 and C.4 or real property owners listed in part D.3 previously owned or operated a healthcare facility (or long-term care facility only for nursing home/rest home applicants) in Massachusetts or any other jurisdiction that:

(1) Has filed for bankruptcy; or,

(2) Was foreclosed upon by a lender/financer; or

(3) Has been placed in receivership?

____ No – Proceed to Question G.3.

____ Yes – **Complete and attach Suitability Application Disclosure Form**.

3. Have all of the corporate officers, directors, or owners listed in parts C.3 and C.4 either individually or severally, complied with all laws of the Commonwealth relating to:

(1) The payment of taxes, reporting of employees and contractors; and

(2) The withholding and remitting of child support; and

(3) Properly registering motor vehicles or trailers as required to be registered in the Commonwealth under M.G.L. c. 90, §3 1/2 and not improperly registering motor vehicles or trailers in another state, or misrepresenting the place of garaging of motor vehicles or trailers in another city or town.

____ Yes – Acute Care Hospitals, proceed to Question G.4; all other applicants proceed to Part H.

____ No – M.G.L. c. 62C, §49A requires that all applicants shall certify, under penalties of perjury, that the applicant has complied with all laws of the commonwealth relating to taxes, reporting of employees and contractors, and withholding and remitting of child support.

4. **ACUTE CARE HOSPITALS ONLY**: Have all the requirements in M.G.L. c.111, §51G been met including:

- Provisions for participation of persons from the primary service are in the oversight of the hospital, if non-profit;
- Assessment of effect of the transaction on the availability of and access to healthcare;
- Disclosure of all financial transactions, including remuneration of all officers of the hospitals affected by the transaction been disclosed **(attach copy)**;
- A public hearing has been or will be held as required by the Department;
- The percentage of revenue allocated to free care same or increased, unless otherwise authorized by the Department;
- Development of a plan for the identification and provision of community benefits, to include essential health services, unless waived by the Department **(attach copy)**; and,
- If a merger or acquisition, a public presentation and evaluation of proposals by board of trustees?

___ Yes. **(Copy of disclosure information regarding all financial transactions and plan for the provision of community benefits attached. Public hearing will be scheduled to be held with DPH staff.)**

___ No – Licensure will not be approved without disclosure and public hearing.

H. SIGNED AND NOTARIZED STATEMENT OF APPLICATION.

I certify, under the pains and penalties of perjury, that I am the proposed licensee, or authorized agent of the proposed licensee, and that the information provided in and submitted with this document is accurate and correct to the best of my knowledge.

I understand that the failure to file a complete and accurate application for an initial license, or the renewal of an existing license may constitute grounds for denial or revocation of a license; and that the Department may not accept an incomplete application.

I understand that ownership and control information must be kept current, and that it is the responsibility of licensees to file changes within 30 days of execution with the Department of Public Health, Division of Health Care Facility Licensure and Certification through its Licensure Coordinator.

I certify that I have read and understand the statutory and regulatory requirements applicable to licensure and operation, and understand that the failure to meet these requirements may be grounds for the denial, revocation or refusal to renew a license, and that any legal or administrative action or claim arising from or related to this application or any resulting license shall be interpreted in accordance with and subject to the judicial and administrative laws, regulations and procedures of the Commonwealth of Massachusetts.

I certify pursuant to M.G.L. c. 62C, §49A that all applicants have complied with all laws of the Commonwealth relating to taxes, the reporting of employees and contractors, and the withholding and remitting of child support; and that no applicant who owns or leases a motor vehicle or trailer that is required to be registered in the Commonwealth under M.G.L. c. 90 has improperly registered the motor vehicle or trailer in another state or misrepresents the place of garaging of the motor vehicle or trailer in another city or town.

I understand that the Department may, at its discretion, request additional information concerning ownership and control to reach its determination of the applicant's suitability for licensure, and that this application shall not be deemed complete until such information has been submitted, received and reviewed by the Department, and that failure to submit such information may result in the return or denial of this application.

I understand that the Department or its agents may visit and inspect this facility or program at any time, without prior notice, in order to determine compliance with state law and applicable regulations, and that all parts of the facility or program, all staff and activities, and all records covered by this application are subject to such visit and inspection.

SIGNED UNDER THE PENALTIES OF PERJURY, this _____ day of

_____ , 20_____.

_____
Applicant or Authorized Agent's Signature

_____
Applicant or Authorized Agent's Printed Name and Title

Subscribed and sworn to before me this _____day of _____, 20_____.

_____
Notary Public

_____
Seal

My commission expires on _____, 20____.