DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH CARE FACILITY
LICENSURE AND CERTIFICATION

SUITABILITY APPLICATION
DISCLOSURE OF ADDITIONAL INFORMATION

The Department of Public Health requires any applicant whose initial application for licensure indicates additional information will be required to complete a determination of suitability to complete all sections of this disclosure form. **Incomplete disclosures will be returned to the applicant without further review by the Department.**

A. APPLICANT INFORMATION:

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

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

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

4. _____ 5. _____
Telephone Number Fax Number

5. _____
Administrator's Name

B. COMPLIANCE HISTORY:

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

___ Yes – **Attached for each occurrence in the last ten years is:**

(A). Detailed explanation specifying:

- Name of individual or corporation and how affiliated;
- Facility name and address;
- Medicare and Medicaid provider numbers;
- Number of licensed beds, if applicable; and,
- The circumstances and how they were resolved.

(B). Copies of all relevant court or administrative agency documents including but not limited to:

- Complaint or notice of agency action;
- Applicant's response; and,
- Settlement agreement, court decision or final agency action.

C. 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 been, 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 –

____ Yes – **Attached for each occurrence in the last ten years is:**

(A). Detailed explanation specifying:

- Name of individual or corporation and how affiliated;
- Facility name and address;
- Medicare and Medicaid provider numbers;
- Number of licensed beds, if applicable; and,
- The circumstances and how they were resolved.

(B). Copies of all relevant court or administrative agency documents including but not limited to:

- Complaint or notice of agency action;

- Applicant's response; and,
- Settlement agreement, court decision or final agency action.

D. FINANCIALS

1. Attach financial information regarding the operation of the facility/agency for which licensure is being sought as follows:

(1) All applicants must submit a business plan and written description of the transaction and supporting documentation to include:

- Next three years' projected profit and loss, in the Center for Health Information and Analysis (CHIA) format as applicable, with assumptions to include payor mix and for long term care facilities, Medicaid residents by payment classification, projected patient days and daily rates.
- Next three years' capital budget.
- Financing commitment or other preliminary financing approval as may be available to the applicant.

(2) Applicants for change of ownership, in addition to the items listed in D.1. (1) above, the prior two years' cost reports as filed with CHIA for the following provider types:

- Nursing Homes: HCF1; HCF2 and/or HCF3, if applicable.
- Rest Homes: HCF4; HCF2 and/or HCF3, if applicable.
- Hospitals: 403 Cost Report
- Clinics:
  - Community Health Centers: CHC Cost Report.
  - Community Mental Health Centers and Family Planning Clinics: UFR with special supplementary schedule.
  - Freestanding Ambulatory Surgical Centers: Not applicable.

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 health 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;
(2) Was foreclosed upon by a lender/financer; or
(3) Has been placed in receivership?

____ No

____ Yes – **Attached for each occurrence in the last ten years is:**

(A). Detailed explanation specifying:

- Name of individual or corporation and how affiliated;
- Facility name and address;

- CMS Certification Number (formerly Medicare Provider Number) and Medicaid provider number;
- Number of licensed beds, if applicable; and,
- The circumstances and how they were resolved.

(B). Copy of relevant court or administrative agency documents including but not limited to:

- Complaint or notice of agency action;
- Applicant's response; and,
- Settlement agreement, court decision or final agency action.

E. 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 Department may require the submission of additional information in the course of its review and that failure to submit such information may result in the return or denial of this application.

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 the 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 improperly registers 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.

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_____.