



## RE: Change of Ownership

Dear Provider:

TMHP has been notified of your change of ownership. Under procedures set forth by the Centers for Medicare and Medicaid Services (CMS) and the Texas Department of State Health Services (DSHS), a change in ownership of a facility does not terminate Medicare eligibility; *therefore, Medicaid participation may be continued provided that the new owners comply with the following requirements:*

1. Obtain recertification as a Title XVIII (Medicare) facility under the new ownership.
2. Complete a Medicaid provider enrollment packet that includes a Medicaid Provider Enrollment Application, Provider Agreement, Provider Information Form, Principal Information Form, Disclosure of Ownership Form, and an IRS W-9 Form.
3. Complete the Statement of Change of Ownership.
4. Complete the Change of Ownership Questionnaire.
5. Provide TMHP a copy of the Contract of Sale (specifically, a signed agreement which includes the identification of previous and current owners).
6. Give a listing of *all* provider numbers affected by the change of ownership. Separate applications and questionnaires are required for each provider number affected by the change of ownership.

Contact TMHP at 1-800-925-9126, option 2, for any questions or assistance in completing the enrollment forms. We look forward to your participation in the Texas Medicaid Program.

Sincerely,  
TMHP Provider Enrollment Department



## Change of Ownership Questionnaire

Please complete the following questions as accurately as possible. This information will be used in determining how the change of ownership will be processed and where past and future cost report settlements will be mailed.

### Previous Owner's Information

Previous Provider's Texas Provider Identifier (TPI): \_\_\_\_\_

Current Fiscal Year End: \_\_\_\_\_ New Fiscal Year End: \_\_\_\_\_

1. Circle the applicable change of ownership reason:

Change in Lease    Merger    Termination

2. Effective Date: \_\_\_\_\_

3. Did CMS consider this a change of ownership? Yes No

4. If Yes, complete the following:

A. Short period dates for previous owner: \_\_\_\_\_ to: \_\_\_\_\_

B. Name of previous owner: \_\_\_\_\_

C. Address of previous owner: \_\_\_\_\_

D. City, State, ZIP: \_\_\_\_\_

E. Tax ID number for previous owner: \_\_\_\_\_

F. Contact name for previous owner: \_\_\_\_\_

G. Telephone number for contact name: \_\_\_\_\_

### New Owner's Information

1. Did the new owner assume liability? Yes No

2. Short period dates for new owner: \_\_\_\_\_ to: \_\_\_\_\_

3. Medicare intermediary for new owner: \_\_\_\_\_

4. Is the new owner chain-affiliated? Yes No

5. Name of new owner: \_\_\_\_\_

6. Address of new owner: \_\_\_\_\_

7. City, State, ZIP: \_\_\_\_\_

8. Tax ID number for new owner: \_\_\_\_\_

9. Contact name for new owner: \_\_\_\_\_

10. Telephone number for contact name: \_\_\_\_\_



### Statement of Change of Ownership

New owner's Medicare cost report fiscal year end (mo./day/year): \_\_\_\_\_  
Submit a copy of the Medicare approval of change of fiscal year end if applicable.  
Does the new owner assume assets and liabilities of prior periods? Yes No  
Complete the appropriate statements below:

**Statement:**

**(A)** The new owner, \_\_\_\_\_,  
(Name of facility)

Texas Provider Identifier (TPI) \_\_\_\_\_,

*has the authority* to accept any assets due and is responsible for any liabilities due to the Title XIX Medicaid Program for cost reporting periods prior to the change of ownership effective \_\_\_\_\_.

**Statement:**

**(B)** The new owner, \_\_\_\_\_, TPI \_\_\_\_\_,  
(Name of facility)

*does not have the authority* to accept any assets due and is **not** responsible for any liabilities due to the Title XIX Medicaid Program for cost reporting periods prior to the change of ownership effective \_\_\_\_\_.

Signed

Title

Date

If the previous owner is liable, please furnish the previous owner's name, address, and telephone number for contact purposes.

Corporation Name

Street address

City

State

Zip

Contact Name

Telephone Number