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 Texas Provider Identifier (TPI): _____

Current Fiscal Year End: _____ New Fiscal Year End: _____

1. Check 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