



DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH CARE QUALITY

INITIAL LICENSURE APPLICATION:
NOTICE OF INTENT TO ACQUIRE/
APPLICATION FOR DETERMINATION OF SUITABILITY

Blank copies of all attachments referenced in this form may be found on the DPH Website under: [Licensure and Medicare/Medicaid Certification](#). **Incomplete applications will be returned to the applicant.** Submit two (2) copies of your completed application with attachments to:

Licensing Coordinator
DPH, Division of Health Care Quality
99 Chauncy Street, 2nd Floor
Boston, MA 02111

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; The Department will notify long term care applicants in HSA V of its authorization to publish notice of intent to acquire under 105 CMR 153.022(B).)

4. _____
Telephone Number

5. _____
Fax Number

5. _____
Administrator's Name

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

6. Application Type:

___ Initial licensure – proceed to Question A. 7.

___ Change of owner for existing facility/agency, license number: .

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

Will number of beds or any services offered change: No___ Yes___ (attach explanation)

7. Provider Type (attach Programmatic Specific Licensure Application):

<input type="checkbox"/>	<i>Nursing Home*</i>	<input type="checkbox"/>	<i>Clinic – All except LSC or ASC</i>
<input type="checkbox"/>	<i>Rest Home*</i>	<input type="checkbox"/>	<i>Clinic – Limited Services</i>
<input type="checkbox"/>	<i>Hospital*</i>	<input type="checkbox"/>	<i>Clinic – Ambulatory Surgery Center</i>
<input type="checkbox"/>	<i>Hospice</i>	<input type="checkbox"/>	<i>ESRD</i>

*May be submitted subsequent to determination of suitability.

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

Facility/Agency Name (name by which you will do business)	
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Facility/Agency Address (Street, City/Town, ZIP)	

9. HOSPITAL AND CLINIC ONLY: Are there satellite sites 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 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 Website: Determination of Need Program](#)):

- ___ **Copy of Approval Letter Attached**
- ___ Not Applicable – Reason: _____

2. Plan Approval (See [DPH Website: Plan Review Program](#)):

- ___ **Copy of Approval Letter Attached**
- ___ Not Applicable – Reason: _____

3. Department of Public Safety or Local Occupancy Certificate (See Table 1 – DPS):

- ___ **Copy Attached For Buildings Occupied By Residents/Patients**
- ___ **To be submitted (new construction only - DPH will not book for survey until received)**
- ___ Not Applicable – Reason: _____

4. Fire Certificate from Local Fire Department:

- ___ **Copy Attached For Buildings 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 Table 2 – Fee Schedule.)

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

Facility/Agency Name (name by which you will do business)	
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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:

□ □ □ □ □ □ □ □ □

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/DHCQ CORI form attached. (If not, explain in attachment.)

d. _____ e. _____
Name #2 Title

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

Completed DPH/DHCQ CORI form attached. (If not, explain in attachment.)

g. _____ h. _____
Name #3 Title

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

Completed DPH/DHCQ CORI form attached. (If not, explain in attachment.)

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j. _____ k. _____
Name #4 Title

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

Completed DPH/DHCQ CORI form attached. (If not, explain in attachment.)

m. _____ n. _____
Name #5 Title

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

Completed DPH/DHCQ 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/DHCQ CORI form attached. (If not, explain in attachment.)

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

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

Completed DPH/DHCQ CORI form attached. (If not, explain in attachment.)

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

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

Completed DPH/DHCQ CORI form attached. (If not, explain in attachment.)

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

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

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

Completed DPH/DHCQ CORI form attached. (If not, explain in attachment.)

m. _____ n. _____
Name #5 Title

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

Completed DPH/DHCQ 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 – Proceed to Part E.
- ___ Yes – The Department may not approve a license application in which the applicant has entered into a agreement which would subject the license to transfer.

3. **NURSING AND REST HOMES ONLY:** Real Property Owners– *Please provide information on all individuals with a 5% more ownership interest in the real property.*

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

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

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- 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 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 on the Suitability Application, Parts C.3 and C.4 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 and director is attached.**

2. Have any of the corporate officers, directors, or owners listed in parts C.3 and C.4 previously owned or operated any health 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 which, either individually or severally:

- (1) 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,

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

(4) Have 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 or disabled person; 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:

Have any of the corporate officers, directors, or owners listed in parts C.3 and C.4 been, either individually or severally, convicted of; entered into any plea agreement; or entered into any settlement agreement in regard to a criminal allegation in Massachusetts or any other jurisdiction pertaining to:

(1) Medicare or Medicaid fraud; or,

(2) Criminal allegation of abuse, neglect or misappropriation involving a home health, homemaker or hospice patient; long term care resident; or an elderly or disabled person.

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 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 which:

(1) Has filed for bankruptcy; or,

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(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; or

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

(3) Properly registering motor vehicles or trailers as required to be registered in the Commonwealth under Chapter 90; 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 – Massachusetts General Laws Chapter 62C, Section 49A requires that all applications shall certify upon application, 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 Massachusetts General Laws, Chapter 111, section 51G been met to include:

- 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?

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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 Quality 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 Massachusetts General Laws Chapter 62C, section 49A that, to the best of my knowledge and belief, the applicant has 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 Chapter 90 has 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.

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.

SIGNED UNDER THE PENALTIES OF PERJURY, this _____ day of

_____ Facility/Agency Name (name by which you will do business)	
_____ Facility/Agency Address (Street, City/Town, ZIP)	Page 10 of 10

_____, 2_____.

Applicant or Authorized Agent's Signature

Applicant or Authorized Agent's Printed Name and Title

Subscribed and sworn to before me this ____ day of _____, 2_____.

Notary Public

My commission expires on _____, 20_____.

(Seal)