LOUISIANA DEPARTMENT OF HEALTH

Health Standards Section (HSS)

KEY PERSONNEL CHANGE FORM

Legal Entity Name: _____

Agency DBA Name: _____

Provider License #: _____**Provider CMS ID # (if applicable):** _____

Address: _____

City, State, Zip: _____

Telephone Number: _____ **Fax Number:** _____

Administrator's Email Address: _____ **Proposed Employee's Email Address:** _____

Check the position that is changing (please check only those appropriate to the Provider Type):

☐**Administrator** (the person with overall responsibility for the day-to-day administrative operations)

☐**Director of Nursing** (the registered nurse providing leadership of nursing services – if applicable)

☐**Medical Director** (the physician providing oversight of the clinical operations – if applicable)

☐**Other**:_____

Name of *previous* employee in this position: _____

Name of *proposed* employee for this position: _____

Effective Date of Change: _____/_____/_____

Verification Date of Current Louisiana Professional License: _____/_____/_____

Please enter the date on which the agency verified the current professional licensure of the proposed employee, *if licensure is a requirement for the position.* The date should precede the effective date of change.

State Incident Management System (SIMS) Access

Intermediate Care Facility for the Developmentally Disabled and Nursing Facilities Only

The *proposed* employee needs access to SIMS: ☐ YES ☐ NO

The *proposed* employee currently has access associated with another provider: ☐ YES ☐ NO

The *previous* employee currently has access to SIMS: ☐ YES ☐ NO

ESF-8 Portal (MSTAT) Access

Intermediate Care Facility for the Developmentally Disabled, Nursing Facilities, Adult Residential Care Providers, and Hospitals Only

The *proposed* employee needs access to the ESF-8 portal: ☐ YES ☐ NO

The *proposed* employee currently has access to the ESF-8 portal associated with another provider: ☐ YES ☐ NO

The *previous* employee currently has access to ESF-8 portal: ☐ YES ☐ NO

Attestations of Compliance

We hereby certify that the proposed employee listed herein meets all state/federal requirements set forth by the Louisiana Department of Health (LDH), HSS; the Centers for Medicare and Medicaid Services; and any other regulatory agency applicable to the Provider Type, to function in the role indicated. We further understand that it is the responsibility of the administrator to ensure that the agency maintains compliance with state/federal regulations on an ongoing basis, and that the LDH, HSS will be promptly notified of any changes to key personnel.

_____	_____	_____
Printed Name of Proposed Employee	Signature of Proposed Employee	Date (mm/dd/yy)
_____	_____	_____
Printed Name of Administrator	Signature of Administrator	Date (mm/dd/yy)

PLEASE NOTE: ***This form must be signed by the proposed employee and the administrator.*** This form is used for all HSS licensed providers/suppliers. Definitions of key personnel may be found in the applicable state licensing regulations for the specific Provider Type.

Louisiana Department of Health, Health Standards Section
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