



**Health Standards Section
Checklist Change of Ownership
AMBULATORY SURGERY CENTER**

| | |
|--------------------------------------|--|
| Application Date: | Date of Change: |
| ASC DBA Name: | ASC Entity/Corporation/Legal Name: |
| ASC Geographical Address: | ASC Mailing Address (if different): |
| ASC Phone: | ASC Fax: |
| Administrator: | Designated Contact Person: |
| Administrator Phone: | Designated Contact Person Phone: |
| Administrator E-Mail Address: | Designated Contact E-Mail Address: |

| DOCUMENTS NEEDED FOR INITIAL LICENSING | |
|--|--------------------------|
| ASC License Application (Form HSS-AS-01) | <input type="checkbox"/> |
| Letter of Intent | <input type="checkbox"/> |
| Disclosure of Ownership (Form HSS-ALL-48) | <input type="checkbox"/> |
| Licensing Fee: \$600.00 | <input type="checkbox"/> |
| Controlled Dangerous Substance Application Copy | <input type="checkbox"/> |
| Secretary of State, Articles of Incorporation | <input type="checkbox"/> |
| If non-profit facility: Approval from AG's office for CHOW | <input type="checkbox"/> |
| Management agreement (if applicable) | <input type="checkbox"/> |
| Proof of insurance including general liability insurance of at least \$300,000 per occurrence; Worker's compensation; Professional liability insurance of at least \$100,000 per occurrence/\$300,000 per annual aggregate, or proof of self-insurance of at least \$100,000 along with proof of enrollment as a qualified health care provider with the Louisiana Patient's Compensation Fund (PCF). If not enrolled in the PCF, professional liability limits shall be \$1 million per occurrence/\$3 million per annual aggregate. LDH Health Standards Section shall be identified as the certificate holder on any policies and any certificates of insurance issued as proof of insurance. | <input type="checkbox"/> |
| Line of Credit of at least \$100,000 | <input type="checkbox"/> |
| Before and After Ownership Diagram | <input type="checkbox"/> |
| DOCUMENTS NEEDED FOR INITIAL CERTIFICATION | |
| CMS Form 377-Request for Certification | <input type="checkbox"/> |
| CMS Form 370-Health Insurance Benefits Agreement | <input type="checkbox"/> |
| 855B Approval Letter from the Fiscal Intermediary | <input type="checkbox"/> |