LOUISIANA DEPARTMENT OF HEALTH

NURSING FACILITIES / SKILLED NURSING FACILITIES: CHANGE OF OWNERSHIP (CHOW) CHECKLIST

EFFECTIVE DATE OF OWNERSHIP TRANSFER		FISCAL INTERMEDIARY	
ENTITY/CORP. NAME (CURRENT)			
DBA NAME (CURRENT)			
ENTITY/CORP. NAME (AFTER CHOW)			
DBA NAME (AFTER CHOW)			
CONTACT PERSON'S NAME			
CONTACT PERSON'S EMAIL			
IS THE NURSING HOME A LICENSED ONLY FACILITY (NOT PARTICIPATING IN MEDICAID OR MEDICARE)?			YES
IS THE NURSING HOME KEEPING THE CURRENT PROVIDER'S MEDICARE AGREEMENT & NUMBER?			YES

A CHOW PACKET CANNOT BE PROCESSED UNTIL THE CHECKLIST & PACKET ARE COMPLETE.
IF TWO OR MORE CHOWS OCCUR, EACH TRANSACTION WILL BE TREATED AS A SEPARATE EVENT & WILL NEED A SEPARATE CHOW PACKET.

☐	LETTER OF INTENT, WHICH MUST INCLUDE: DBA (DOING BUSINESS AS) AND ENTITY NAME OF THE PREVIOUS AND THE NEW OWNER, EFFECTIVE DATE OF CHANGE OF OWNERSHIP, ADDRESS, AND PHONE NUMBER
☐	COPY OF THE SIGNED/DATED LEGAL DOCUMENTATION OF SALE, LEASE, OR MERGER DOCUMENT SHOULD INCLUDE PROVISIONS FOR THE TRANSFER OF THE OPERATIONS/BUSINESS, FACILITY NEEDS REVIEW (FNR), AND THE BUILDING/LAND/EQUIPMENT TO THE NEW BUYERS/LEASERS.
☐	CHOW APPLICATION (HSS-ALL-48)
☐	DISCLOSURE OF OWNERSHIP (HSS-1513L)
☐	STATE FIRE MARSHAL ON-SITE INSPECTION REPORT
☐	OFFICE OF PUBLIC HEALTH INSPECTION REPORT
☐	PROOF OF CRIMINAL BACKGROUND CHECK (CBC) ON THE ADMINISTRATOR AND ALL OWNERS. IF OWNER IS A CORPORATION, SUBMIT PROOF OF CBCS ON ALL BOARD OF DIRECTORS AND PRINCIPAL OWNERS.
☐	SECRETARY OF STATE - ARTICLES OF INCORPORATION/ARTICLES OF ORGANIZATION
☐	8X11 FLOOR SKETCH
☐	HSS PAYMENT TRANSMITTAL FORM & LICENSE FEES ($600 PLUS $5 PER UNIT/ROOM)

► ALL PROVIDERS PARTICPATING IN MEDICARE OR MEDICAID SHALL PROVIDE THE FOLLOWING ◄

☐	RESIDENT TRUST FUND BALANCE INFORMATION
☐	SIGNED/DATED SURETY BOND AGREEMENT IN THE NAME OF THE NEW PROVIDER
☐	COPY OF LETTER FROM OFFICE OF MANAGEMENT & FINANCE REGARDING OUTSTANDING FEES
☐	LTC FACILITY APPLICATION FOR MEDICARE/MEDICAID FORM (CMS-671)

► ALL PROVIDERS PARTICPATING IN MEDICARE SHALL PROVIDE THE FOLLOWING ◄

☐	INTENTIONS REGARDING MEDICARE CERTIFICATION / AGREEMENT (FORM HSS-NH-15)
☐	HEALTH INSURANCE BENEFIT AGREEMENT (CMS-1561) WITH ORIGINAL SIGNATURE IN "ACCEPTED FOR SUCCESSOR PROVIDER OF SERVICES" (BLOCK 3)
☐	COPY OF THE FACILITY'S HOSPITAL TRANSFER AGREEMENT(S)
☐	ELECTRONIC VERIFICATION FROM THE OFFICE OF CIVIL RIGHTS (OCR) OF SUCCESSFUL SUBMISSION OF THE ATTESTATION
☐	855A APPROVAL LETTER FROM THE FISCAL INTERMEDIARY

Revised 10/2019 , 8/2020, 12/2023, 03/2026

Bienville Building ▪ 628 N. Fourth St. ▪ P.O. Box 3767 ▪ Baton Rouge, Louisiana 70821-3767
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MAIL PAYMENT AND FORM TO:
LDH LICENSING PAYMENTS
P.O. BOX 734350
DALLAS, TX 75373-4350

SCAN AND EMAIL PACKET TO:
HSS-NH-LICENSING@LA.GOV

OR

MAIL PACKET TO:
LDH HEALTH STANDARDS SECTION
P.O. BOX 3767
BATON ROUGE, LA, 70821-3767

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