

MISSISSIPPI STATE DEPARTMENT OF HEALTH

TRANSFER COUNTY OF A HOME HEALTH AGENCY

(Must be accompanied by processing fee \$2,500.00 minimum)

One (1) original Transfer of County of a Home Health Agency application with the Certification Page must be mailed, or hand delivered to the Mississippi State Department of Health, and a complete copy of the application and attachments should be emailed to HPRD@msdh.ms.gov. Be sure to include the following words in the subject line of the e-mail: **Transfer of County of a Home Health Agency application submission.**

Please provide a Table of Contents referencing the Exhibits along with dividers or tabs to distinguish the appropriate Exhibit documentation.

The original application including attachments and filing fee should be mailed or hand delivered to the following address:

Division of Health Planning and Resource Development
Mississippi State Department of Health - Office of Health Protection
143-B Le Fleur's Square
Jackson, MS 39211

Note: (CONFIDENTIAL Information)

If the CON Application contains information deemed CONFIDENTIAL, please submit a statement (*the statement must provide an explanation as to why the applicant considers the information specified to be deemed CONFIDENTIAL*); clarifying why the allocated information is deemed CONFIDENTIAL.

CONFIDENTIAL information must be submitted under a separate cover, isolated from the CON application.

Part I: Facility Information

Facility Name:					
Address:					
City:		State:		Zip Code:	
County:		Telephone:			
Number/Type of Licensed Beds:					
Type of Organization: (County owned, non-profit, for profit, etc.)					

Part II: Purchaser/Lessee Information

Name of Organization:					
Address:					
City:		State:		Zip Code:	
County:		Telephone:			
Changes in Number/Type of Licensed Beds:					
Type of Organization (non-profit, for profit, etc.)					
Primary Contact Person					
Name:		Title or Position:			
Firm:					
Address:					
City:		State:		Zip Code:	
Telephone:		Fax:			
E-mail Address:					

Part III: Seller/Lessor Information

Name of Organization:					
Address:					
City:		State:		Zip Code:	
Owner(s):		Operator(s):			
Type of Organization (non-profit, for profit, etc.)					

Primary Contact Person				
Name:		Title or Position:		
Firm:				
Address:				
City:		State:	Zip Code:	
Telephone:			Fax:	
E-mail Address:				

Part IV: Type/Value of Consideration

Type Transaction:	Purchase ()	Lease ()	Other ()
Describe other transaction:			
List County(ies) being transferred:			
Lease/Purchase Cost: \$		Fair Market Value: \$	

Part V: Expected Date of Transaction: _____

Part VI: Provide the following:

The proposed (agreed upon) sales contract/lease agreement executed by the principals.

Part VII: Complete and sign the attached Certification page.

Submitted by:

Name (Print or type)

Title

Date

Address (if different than page 1)

CERTIFICATION

I (we) do solemnly swear or affirm on behalf of _____ and _____, after diligent research, inquiry and study, that the information and material, contained in this foregoing Notice of Intent to Transfer County of a Home Health Agency (HHA) is true, accurate, and correct, to the best of my (our) knowledge and belief. It is understood that the Mississippi State Department of Health, will rely on this information and material in making its decision as to approve the licensure of the HHA, and if it is found that the application contains distorted facts or misrepresentation or does not reveal truth and accuracy, the Department may refrain from further review and consider it rejected. It is further understood that the approval and license are granted based upon evidence contained in this application, such approval/license may be revoked, canceled or rescinded if the Department of Health determines its findings were based on evidence not true, factual, accurate, or correct.

I (we) solemnly swear or affirm that no revision or alteration of the Notice submitted will be made without notifying the Mississippi State Department of Health.

_____ Signature (Purchaser)	_____ Signature (Seller)
_____ Title	_____ Title

Name of Facility

Sworn to and subscribed before me, this the _____ day of _____, 20 ____.

Notary Public

My Commission Expires