LHCSA Application

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Webinar Objectives

- Background
- Licensed Home Care Services Agency (“LHCSA”) Application
  - Section A: Identifying Data
  - Section B: Program Analysis
  - Section C: Public Need Review
  - Section D: Legal Information
  - Section E: Change of Ownership
  - Section F: Additional Information
  - Section G: Financial Resources

Background

- In April 2018, the New York State Department of Health (“DOH”) imposed a LHCSA moratorium as part of the 2018-2019 New York State Executive Budget
- The moratorium prohibited:
  - The receipt and processing of applications to establish new LHCSAs;
  - Certain change of ownership applications including those where a new proposed operator replaced the current operator of a LHCSA; and
  - Partial change of ownership applications requiring Public Health and Health Planning Council (“PHHPC”) approval.
- The moratorium ended in April 2020, but the revised LHCSA application was not released until August 17, 2022.
- The new LHCSA application will allow parties to submit applications for:
  - Establishment of new LHCSAs;
  - Change of ownership; and
  - Expansion of Restricted Licenses.

Licensed Home Care Services Agency Application Article 36

- Instructions:
- Please refer to the following chart to identify which Sections must be completed for each application Type.

Application Type	Sections to be Completed
New LHCSA	A, B, C, D, F, G
Change of Ownership	A, B, C, D, E, F, G
Expansion of Restricted License	A, B, C, D, F, G

- Contents:
- Section A: Identifying Data
- Section B: Program Analysis
- Section C: Public Need Review
- Section D: Legal Information
- Section E: Change of Ownership
- Section F: Additional Information
- Section G: Financial Resources

Section A: Identifying Data – All Applicants

Agency Information: Enter the name and address of the agency as it is to appear on the license. If an Assumed Name (d/b/a) is to be used, this must be entered as the name of the agency.

Name of Agency:

Street Address:

City: State: Zip:

Telephone: Fax:

Operator Information: Enter the name and address of the legal operating entity. The name must be spelled exactly as it was filed or is to be filed with the New York State Department of State. If the names and addresses of the operator are the same as for the agency, check the box below.

Agency and Operator Information are the same ☐

Name of Legal Operating Entity:

Street Address:

City: State: Zip:

Telephone: Fax:

Section A: Identifying Data – All Applicants (cont'd)

LICENSE NO.

State of New York
Department of Health
Office of Health Systems Management

EFFECTIVE DATE 06/01/15

HOME CARE SERVICE AGENCY

LICENSE

Best Home Care
Agency Address

OPERATOR:
VOLUNTARY CORPORATION
Operator Name
Operator Address

HAS BEEN GRANTED THIS LICENSE TO OPERATE PURSUANT TO ARTICLE 36 OF THE PUBLIC HEALTH LAW FOR THE HEALTH SERVICES SPECIFIED:

COUNTY(S) SERVED

WESTCHESTER
BRONX
KINGS
NEW YORK
QUEENS
RICHMOND

SERVICE

NURSING
HOME HEALTH AIDE
PERSONAL CARE
MEDICAL SOCIAL WORK

AREA ADMINISTRATOR

ACTING COMMISSIONER M.D., J.D

DOH 502K (5/14)

THIS CERTIFICATE MUST BE CONSPICUOUSLY DISPLAYED ON THE PREMISES.

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Section A: Identifying Data – All Applicants (cont’d)

Section A: Identifying Data – All Applicants (cont’d)

Check the box which indicates the type of ownership for the legal operating entity.

□ For-Profit Corporation	□ Sole Proprietor	□ Public
□ Not-for-Profit Corporation	□ Partnership	□ Other
□ Limited Liability Company		

Contact Information: Enter the name, address and contact information for the person who is assigned to provide additional information regarding the application. This should be the same as the primary contact entered into the General Tab in the NYSE-CON submission.

TIP: At least one of the primary contacts must be a legal owner of the entity.

Section A: Identifying Data – All Applicants (cont'd)

Resolution (Required for all applicants)

All applicants must submit a certified copy of the Resolution of the Board of Directors or Trustees of a corporation, members of a Limited Liability Company, partners in a partnership, the local legislature or Board of Supervisors for public agencies or other governing body having jurisdiction over the agency program. This is an official document authorizing the application to be submitted to the NYS Department of Health for licensure.

BEST HOME CARE INC.

ACTION BY BOARD OF DIRECTORS WITHOUT A MEETING

The undersigned, being all the directors of BEST HOME CARE INC., a New York not-for-profit corporation (the "Corporation"), do hereby consent that a meeting of the board of directors of the Corporation be dispensed with, for the purposes hereof, and do hereby take the following actions by written consent ("Consent"), pursuant to the provisions of Section 708(b) of the Not-for-Profit Corporation Law of the State of New York:

Adoption of the following preamble and resolutions:

	WHEREAS, the Corporation has determined it to be in the best interest to apply for a licensure as a home care services agency.
	NOW, THEREFORE, BE IT
Submission to NYS Dept. of Health for Licensure	**RESOLVED**, that the Corporation hereby seek licensure with the New York State Department of Health and approves the submission of the Licensed Home Care Services Agency Licensure Application to the New York State Department of Health along with a certified copy of this Consent and all other documents as deemed necessary to effectuate the application process (the "Application"); and be it further
	RESOLVED, that any officer of the Corporation be, and each hereby is, authorized and directed, for and on behalf of the Corporation to execute and deliver the Application to effect such licensing and to take all such other actions as deemed necessary for the purpose of filing said Application with the New York State Department of Health.
General Authority to Effectuate Resolutions	**RESOLVED**, that each officer of the Corporation be, and hereby is, authorized to do or cause to be done, in the name and on behalf of the Corporation, any and all such acts and things and to execute, deliver and file, in the name and on behalf of the Corporation, any and all such agreements, applications, certificates and other documents and instruments, as any such officer may deem necessary, advisable or appropriate to effectuate the foregoing resolutions.
Counterpart and Signatures	**RESOLVED**, that this Consent may be signed in one or more counterparts, which may be delivered by facsimile or by email or other internet transmission of .pdf, .jpg, .tiff, or other image files or other signature mechanism, each of which together shall be deemed an original, and all of which shall be deemed one instrument notwithstanding that all directors have not signed the same counterpart.

[SIGNATURE PAGE FOLLOWS] Section Break (Next Page)

SAMPLE- FOR DEMONSTRATION PURPOSES ONLY

Section B: Program Analysis

Section B: Program Analysis

Type of Application (check the box below that best describes the application):
□ Initial Licensure □ Asset Purchase □ Other Acquisition of Control
□ Stock/Membership Transfer □ Merger □ Expand Restricted License

Project Narrative
All applicants must submit a project narrative that describes the purpose of the application. If the application is being submitted as a rebuttal to the Public Need requirement, the narrative must include evidence-based data which supports the applicant's claims. If the application is exempt from Public Need review, the narrative must reference the exception.

Part 1: Program Characteristics

Indicate on the following table the services you will be providing, the method of delivery and the availability of each service. For each service, indicate by full-time equivalents (FTE) the anticipated number of personnel, both contract staff and agency employees, needed to sufficiently meet the needs of the projected caseload for the first year of operations.

TIP: At least one Registered Nurse must be employed directly by the agency for the purpose of supervision of Home Health Aides and/or Personal Care Aides and other nursing tasks required.

TIP: If applying for a LHCSA to service an ALP, only Nursing, HHA and PCA services can be provided. If applying for a LHCSA will offer a NFP program, only nursing services may be provided.

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Table B1 - Program Staffing Plan

Service	Direct	Contract	Availability (Hours & Days per Week)	Number of FTEs	Projected Number	
					Cases	Visits
Nursing	1	2	Monday-Friday, 9 am-5 pm	3	30	30
Home Health Aide						
Personal Care Aide	20		Monday – Friday, 8 am-10 pm	20	30	40
Physical Therapy						
Occupational Therapy	2	1	Monday-Friday, 9 am-5 pm	2	5	3
Respiratory Therapy						
Speech-Language Pathology						
Audiology						
Medical Social Work						
Nutrition						
Homemaker						
Housekeeper						
Medical Supplies, Equipment & Appliances						

Section B: Program Analysis (cont'd)

Indicate on the following table the counties proposed to be served. Change of Ownership applicants and applicants seeking to expand the service area of a restricted license should indicate the currently approved service area and any proposed changes. All of the counties requested must be in the same DOH Regional Area region (see map below).

TIP: Initial Licensure applicants must request 5 counties in one DOH region with an exception that one of the requested counties be contiguous to the requested counties.
TIP: Change of ownership applicants for LHCSAs actively serving 25 patients will only be exempt from a public need review if the proposed operator seeks to serve patients within the LHCSA's approved planning area.

Table B2 – Geographical Service Area

County	Current	Proposed
Wayne		✓
Ontario		✓
Seneca		✓
Yates		✓
Cayuga		✓

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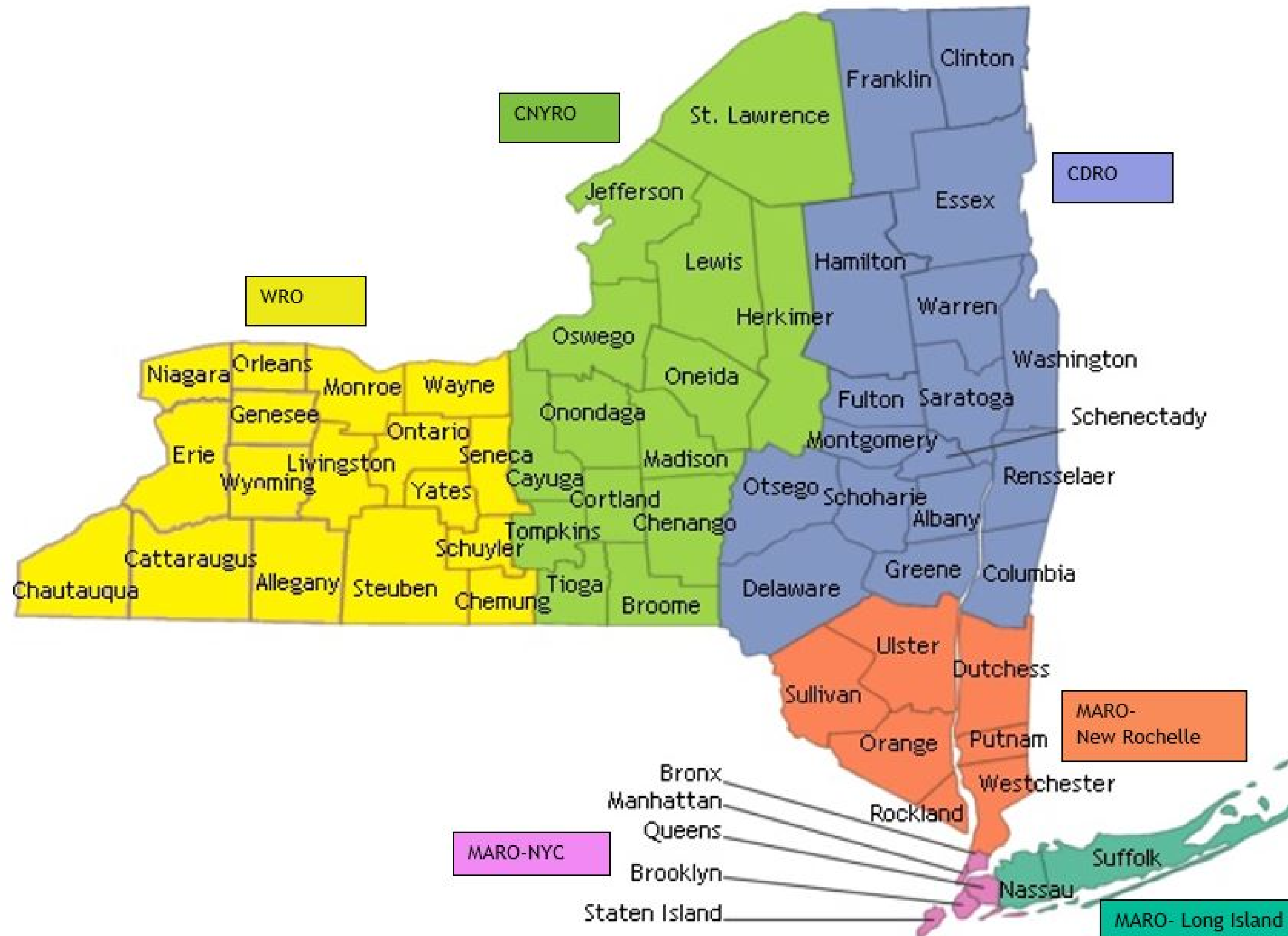
Section B: Program Analysis (cont'd)



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Section C: Public Need Review

1. Is this application affiliated with a program exempt from Public Need review?
   □ Yes □ No

Applications affiliated with a program exempt from Public Need Review include:

- Certain restricted license applicants (LHCSAs affiliated with an ALP, PACE, NFP, or CCRC). “Affiliated” shall mean common ownership.

- Certain applicants seeking a change of ownership or control are exempt from public need if the LHCSA is actively serving at least 25 patients. “Actively serving” means an agency has a plan of care in place for the patient and is providing services to the patient in their home.

- All other applicants will need to overcome a rebuttable presumption that there is no public need for a new LHCSA or LHCSA expansion where there already exists at least five LHCSAs in the particular service area (i.e. the county) actively serving 25 or more patients.

Section C: Public Need Review

Counties with No Need (20) – The Applicant must submit a rebuttal to the presumption of "no need" for each of the counties below:

Albany	Monroe	Richmond
Bronx	Nassau	Rockland
Broome	New York	Saratoga
Chautauqua	Onondaga	Suffolk
Dutchess	Orange	Ulster
Erie	Putnam	Westchester
Kings	Queens	

Counties with Presumed Need (42) – The Applicant may submit an application for establishment of a LHCSA in the following counties:

Allegany	Hamilton	Schenectady
Cattaraugus	Herkimer	Schoharie
Cayuga	Jefferson	Schuyler
Chemung	Lewis	Seneca
Chenango	Livingston	St. Lawrence
Clinton	Madison	Steuben
Columbia	Montgomery	Sullivan
Cortland	Niagara	Tioga
Delaware	Oneida	Tompkins
Essex	Ontario	Warren
Franklin	Orleans	Washington
Fulton	Oswego	Wayne
Genesee	Otsego	Wyoming
Greene	Rensselaer	Yates

Section C: Public Need Review (cont'd)

2. Is this application being submitted as a rebuttal to Public Need? □ Yes □ No

Applications which must include a rebuttal to Public Need are:

- Applications seeking initial licensure in a county in which there are already five (5) or more LHCSAs, each actively serving 25 or more patients. (20 Counties with no need)

- Change of ownership applicants seeking to serve patients outside of the approved service area of the agency being acquired

- A currently licensed LHCSA affiliated with an ALP, PACE, NFP, or CCRC seeking to serve patients outside of the affiliated program.

- A currently licensed LHCSA affiliated with an ALP, PACE, NFP, or CCRC seeking to expand their restricted license into a new planning area

Section C: Public Need Review (cont'd)

3. What information should be included in the applicant's rebuttal information?

-These applications would seek to address a serious concern or difficulty accessing homecare services due to minority status, age, medical history, case complexity or payment source as specified in 10 NYCRR Part 765-1.16(d).

Relevant factors to be considered include:

- the demographics and/or health status of the residents in the planning area or the state, as applicable;
- documented evidence of the unduplicated number of patients on waiting lists who are appropriate for and desire admission to a licensed home care service agency but who experience a long waiting time for placement;
- the number and capacity of currently operating licensed home care services agencies;
- the quality of services provided by existing agencies;
- the availability and accessibility of the workforce;
- personnel and resources dedicated to adding and training additional members of the workforce including committed resources in an organized training program;
- cultural competency of existing agencies; and
- subpopulations requiring specialty services.

Section C: Public Need Review (cont'd)

TIP: Any factors applicable to an applicant's rebuttal should be included in the proposal.

TIP: The applicant must submit a rebuttal to address each county individually where there is a presumption of no need.

TIP: Information provided must be evidence-based data (e.g., statistics, census data, studies, current population survey, health surveys conducted at the state level, surveys or questionnaires).

Section D: Legal Documents

Instructions: This section must be completed by all applicants. Select the type of ownership below (from Items A through G) which applies to this application. Note that the items beneath each ownership type must be submitted for the one that is selected. Review the information required in Item G (Related Organization Information) and, if appropriate, provide the required details as an attachment. Schedule 1 must be completed as indicated in Items A through G. Note that Schedule 1s must be signed individually. **Note: Schedule 2D compliance reports for out-of-state affiliated health care facilities must be included with the NYSE-CON application at the time of submission. Please refer to the "Frequently Asked Questions" document for guidance.**

Section D: Legal Documents (cont'd)

TIP: Applicants must obtain Schedule 2D compliance reports directly from the other states.

TIP: If you would like to change the legal entity of your agency, under Article 36 of the New York Public Health Law, a change in legal entity is considered a formal change of ownership and will require submission of a full CON application and will also be subject to a need and financial review. Once the DOH makes a recommendation, PHHPC will consider the CON application.

TIP: If you would like to change the legal or assumed name (dba), or use a new assumed name (dba), a request for approval must be submitted to LHCSA@health.ny.gov with the proposed Certificate of Amendment, the current and proposed names, an explanation of the nature of and reasons for the requested name change, and other pertinent information and documents which DOH may request. If DOH approves the change, it will notify the agency by letter and the filing must be made with the NY DOS and then submitted to the DOH.

Section D: Legal Documents (cont'd)

□ **A. SOLE PROPRIETOR**

Submit the following:

- Schedule 1
- Copy of the existing or proposed certificate of doing business under an assumed name
- Copy(s) of any agreement(s) relating to the proposed transfer of the business interest in the Agency's operation

Section D: Legal Documents (cont'd)

□ **B. PARTNERSHIP**

Submit the following:

- •Schedule 1 for each partner
- •Complete list of partners, with percent partnership
- •Copy of the existing or proposed certificate of doing business under an assumed name
- •Copy of the existing or proposed partnership agreement
- •Copy(s) of any agreement(s) relating to the proposed transfer of partnership interests

TIP: The partnership agreement must include specific language required under 10 NYCRR § 765-1.2.

Section D: Legal Documents (cont'd)

□ **C. LIMITED LIABILITY COMPANY**

Submit the following:

- Schedule 1 for each member
- Complete list of members indicating the percent of ownership of each member
- Complete list of any managing members
- Copy of existing or proposed articles of organization
- Copy of existing or proposed operating agreement
- Copy of an existing or proposed certificate of doing business under an assumed name
- Copy(s) of any agreement(s) relating to the proposed transfer of membership interests (if applicable)
- Copy of certificate of approval to do business in New York State (if applicable)

Section D: Legal Documents (cont'd)

□ **D. NOT-FOR-PROFIT CORPORATION**

Submit the following:

- Schedule 1 for each board member and director
- Copy of the existing or proposed certificate of incorporation or copy of the executed or proposed certificate of amendment, merger or consolidation, or application for authority where appropriate
- Copy of the existing or proposed certificate of doing business under an assumed name
- Complete list of officers and directors indicating position or title of each (i.e. board member, chairperson, treasurer, etc.)
- Copy(s) of any agreement(s) relating to the proposed transfer of the business interest in the agency operation
- Copy of the existing or proposed bylaws
- Copy of certificate of approval to do business in New York State (if applicable)

TIP: Documentation demonstrating the designation of an agent for service of process is required.

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Section D: Legal Documents (cont'd)

□ **E. BUSINESS CORPORATION**

New **or** *existing* corporation proposing the operation of the agency. Submit the following:

- Each principal stockholder (holder of 10% or more of the issued and outstanding stock), board officer and member of the board of directors must submit a Schedule 1
- Copy of the existing or proposed Certificate of Incorporation and a copy of the executed or proposed certificate of amendment, merger, or consolidation or application for authority where appropriate
- Copy of the existing or proposed certificate of doing business under an assumed name (if applicable)
- Complete list of all board officers, directors, indicating position or title of each (i.e. board member, treasurer, etc.)
- Complete list of all principal stockholders, including: the number of authorized shares, the number of issued shares, the number of shares of stock to be owned by each and the number of unissued shares
- Copy of the existing or proposed bylaws
- Copy of certificate of approval to do business in New York State (if applicable)
- Copy(s) of any agreement(s) relating to the proposed transfer of stock interests (if applicable)

TIP: Documentation demonstrating the designation of an agent for service of process is required.

Section D: Legal Documents (cont'd)

- **F. PUBLIC AGENCIES/PUBLIC BENEFIT CORPORATIONS**

  The Public Agency/Public Benefit Corporation must submit the full name and address, and the license/certificate number, for all agencies or facilities that are operated by the applicant and certified or licensed for the provision of health care

Section D: Legal Documents (cont'd)

- **G. RELATED ORGANIZATION INFORMATION**

  1. List the full legal name and the address of the principal office and place of doing business of any existing or proposed parent corporation, controlling person or controlling organization which directly or indirectly, through one or more intermediaries, possesses or will possess the ability to direct or cause the direction of the actions, management or policies of the person, corporation, organization or other entity that is licensed as the operator of the subject home care agency or that is applying for approval as a licensed home care agency

Section D: Legal Documents (cont'd)

2. With respect to each parent corporation, controlling person or other controlling organization identified in response to item (1) above:

a. List the full name of each member of the board of directors, board officer, controlling person, principal stockholder, sponsor of such parent corporation or controlling person or organization. Each principal stockholder, board officer and member of the board of directors must submit a Schedule 1

b. List the full legal name and the address of the principal office and place of doing business of any hospital, residential health care facility, diagnostic and/or treatment center, adult care facility, mental health facility, home health care or personal care program or agency, or other health care facility or program, regardless of location, owned or operated by such parent corporation or controlling person or organization, together with a photocopy of any operating license, permit or certificate issued for such facility or program, the full name of the issuing agency and dates of ownership

c. Describe in detail the relationship between the applicant and any parent corporation, controlling person or organization and describe in detail the method or mechanism by which control over the licensed home care services agency is or will be effectuated (e.g. stock ownership, membership arrangement, common officers, directors or stockholders or other arrangement)

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Section D: Legal Documents (cont'd)

3. With respect to any existing or proposed parent corporation or controlling person or organization identified in response to question (1) above:

a. List the full legal name and the address of the principal office and place of doing business of any subsidiary corporation or organization that owns or operates any hospital, residential health care facility, diagnostic and/or treatment center, adult care facility, mental health facility, home health care or personal care program or agency or other health care facility or program, regardless of location, and the full legal name and the address of the principal office and place of doing business of any such health care facility or program, together with a photocopy of any operating license, permit or certificate issued for such facility or program, and the full name of the issuing agency and dates of ownership

b. List the full name of each of the members, directors, controlling persons, principal stockholders, board officers and sponsors of each subsidiary corporation or organization identified in response to (3) (a) above

c. Describe in detail the relationship between the applicant, parent corporation, controlling person or organization and each subsidiary corporation or organization identified in response to (3) (a) above and describe in detail the method or mechanism by which control over the subsidiary is or will be effectuated (e.g. stock ownership, membership arrangement, common officers, directors or stockholders or other arrangement)

N.B. Whenever a requested legal document has been amended, modified or restated, all amendments, modifications and/or restatements must also be submitted.

Schedule 1

Schedule 1
All CON Applications

Contents:

- **Acknowledgement and Attestation**
- **General Information**
- **Contacts**
- **Affiliated Facilities/Agencies**

Schedule 1 (cont'd)

Acknowledgement and Attestation

I hereby certify, under penalty of perjury, that I am duly authorized to subscribe and submit this application on behalf of the applicant:

I further certify that the information contained in this application and its accompanying schedules and attachments are accurate, true and complete in all material respects. I acknowledge and agree that this application will be processed in accordance with the provisions of articles 28, 36 and 40 of the public health law and implementing regulations, as applicable.

SIGNATURE:	DATE
PRINT OR TYPE NAME	TITLE

General Information

		Title of Attachment:
Is the applicant an existing facility? If yes, attach a photocopy of the resolution or consent of partners, corporate directors, or LLC managers authorizing the project.	YES ☐ NO ☐	
Is the applicant part of an "established PHL Article 28* network" as defined in section 401.1(j) of 10 NYCRR? If yes, attach a statement that identifies the network and describes the applicant's affiliation. Attach an organizational chart.	YES ☐ NO ☐	

Contacts

The Primary and Alternate contacts are the only two contacts who will receive email notifications of correspondence in NYSE-CON. ***At least one of these two contacts should be a member of the applicant.*** The other may be the applicant's representative (e.g., consultant, attorney, etc.). What is entered here for the Primary and Alternate contacts should be the same as what is entered onto the General Tab in NYSE-CON.

Primary Contact	NAME AND TITLE OF CONTACT PERSON	CONTACT PERSON'S COMPANY	
	BUSINESS STREET ADDRESS		
	CITY	STATE	ZIP
	TELEPHONE	E-MAIL ADDRESS	

Alternate Contact	NAME AND TITLE OF CONTACT PERSON	CONTACT PERSON'S COMPANY	
	BUSINESS STREET ADDRESS		
	CITY	STATE	ZIP
	TELEPHONE	E-MAIL ADDRESS	

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Schedule 1 (cont'd)

New York State Department of Health
Certificate of Need Application

Schedule 1

The applicant must identify the operator's chief executive officer, or equivalent official.

CHIEF EXECUTIVE			
NAME AND TITLE			
BUSINESS STREET ADDRESS			
CITY	STATE	ZIP	
TELEPHONE	E-MAIL ADDRESS		

The applicant's lead attorney should be identified:

ATTORNEY		
NAME	FIRM	BUSINESS STREET ADDRESS
CITY, STATE, ZIP	TELEPHONE	E-MAIL ADDRESS

If a consultant prepared the application, the consultant should be identified:

CONSUTANT		
NAME	FIRM	BUSINESS STREET ADDRESS
CITY, STATE, ZIP	TELEPHONE	E-MAIL ADDRESS

The applicant's lead accountant should be identified:

ACCOUNTANT		
NAME	FIRM	BUSINESS STREET ADDRESS
CITY, STATE, ZIP	TELEPHONE	E-MAIL ADDRESS

Please list all Architects and Engineer contacts:

ARCHITECT and/or ENGINEER		
NAME	FIRM	BUSINESS STREET ADDRESS
CITY, STATE, ZIP	TELEPHONE	E-MAIL ADDRESS

ARCHITECT and/or ENGINEER		
NAME	FIRM	BUSINESS STREET ADDRESS
CITY, STATE, ZIP	TELEPHONE	E-MAIL ADDRESS

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Schedule 1 (cont'd)

New York State Department of Health
Certificate of Need Application

Schedule 1

Other Facilities Owned or Controlled by the Applicant
Establishment (with or without Construction) Applications only

NYS Affiliated Facilities/Agencies
Does the applicant legal entity or any related entity (parent, member or subsidiary corporation) operate or control any of the following in New York State?

FACILITY TYPE - NEW YORK STATE	FACILITY TYPE	
Hospital	HOSP	Yes ☐ No ☐
Nursing Home	NH	Yes ☐ No ☐
Diagnostic and Treatment Center	DTC	Yes ☐ No ☐
Midwifery Birth Center	MBC	Yes ☐ No ☐
Licensed Home Care Services Agency	LHCSA	Yes ☐ No ☐
Certified Home Health Agency	CHHA	Yes ☐ No ☐
Hospice	HSP	Yes ☐ No ☐
Adult Home	ADH	Yes ☐ No ☐
Assisted Living Program	ALP	Yes ☐ No ☐
Long Term Home Health Care Program	LTHHCP	Yes ☐ No ☐
Enriched Housing Program	EHP	Yes ☐ No ☐
Health Maintenance Organization	HMO	Yes ☐ No ☐
Other Health Care Entity	OTH	Yes ☐ No ☐

Upload as an attachment to Schedule 1, the list of facilities/agencies referenced above, in the format depicted below:

Facility Type	Facility Name	Operating Certificate or License Number	Facility ID (PFI)

Out-of-State Affiliated Facilities/Agencies
In addition to in-state facilities, please upload, as an attachment to Schedule 1, a list of all health care, adult care, behavioral, or mental health facilities, programs or agencies located outside New York State that are affiliated with the applicant legal entity, as well as with parent, member and subsidiary corporations, in the format depicted below.

Facility Type	Name	Address	State/Country	Services Provided

In conjunction with this list, you will need to provide documentation from the regulatory agency in the state(s) where affiliations are noted, reflecting that the facilities/programs/agencies have operated in substantial compliance with applicable codes, rules and regulations for the past ten (10) years (or for the period of the affiliation, whichever is shorter). More information regarding this requirement can be found in Schedule 2D.

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Section E: Change of Ownership

1. The currently approved operator of the LHCSA being acquired must submit a signed and notarized attestation which includes the following:

   a. The number of patients currently served in each county for which they are approved to serve.

   b. A statement that reads "In accordance with the requirements of 10 NYCRR 765-2.3 (g) {Agency Name} will promptly surrender their Licensed Home Care Services Agency license(s) to the NYS Department of Health when they cease providing home care services."

   c. A certified copy of the Resolution of the governing authority of the agency being acquired. The Resolution must include an agreement which states that all individual owners of the operating entity authorize the sale of the agency and understand that the actual transfers of ownership interest cannot occur until after all necessary approvals are acquired from the New York State Department of Health and the Public Health and Health Planning Council.

N.B. In accordance with 765-1.16(c)(2), applications for licensure based on a change of ownership of agencies actively serving at least 25 patients will not be subject to Public Need review and will only be evaluated on financial feasibility and the character and competence of the proposed operator. If the applicant seeks to serve patients outside of the previously approved counties they will be subject to a need review for each additional county requested.

TIP: An agency that submitted an affidavit for approval as part of establishing a new controlling entity above the current operator must submit an application for approval of the controlling entity no later than 30 days after the release of the application (September 16, 2022)

Section F: Additional Information

Part 1 – All Applicants

1. Is this project associated with a Franchise? □ Yes □ No
   - If yes, a copy of the Franchise Agreement is required. Attachment #_____.
2. Is there a Management Contract associated with this project? □ Yes □ No
   - If yes, a copy of the Management Contract is required. Be advised that management contracts must receive prior approval by the NYS Department of Health. Attachment #_____.
3. Attach a description of the client and patient groups to be served. Attachment #_____.
4. Attach a description of the Quality Assurance Program, which will be used to evaluate the home care services provided. Please refer to the Quality Assurance Committee Guidelines provided to assist you in developing your Quality Assurance Program. Please note: The Quality Assurance Committee must include at least one nurse. Attachment #_____.
5. Attach an organizational chart which shows the legal structure of the applicant's corporate entity. This chart must depict the relationship to any existing or proposed parent entity, controlling person, or subsidiary. This should include: Agency name, Board of Directors, all appropriate branches, divisions and subdivisions and all parent and sibling entities; subsidiaries.
   - **For Change of Ownership Applications**: Provide two (2) organizational charts, one depicting the current ownership structure and one depicting the proposed ownership structure. Attachment #_____.

Section F: Additional Information (cont'd)

Part 2 – Initial Licensure Applicants Only

This statement must be reviewed and signed by a duly authorized representative of the applicant seeking approval for initial licensure as an indication that no services requiring home care services agency licensure are presently being provided and will not be provided until such time as a license is received.

Section G: Financial Resources

Part 1 – Sources of Working Capital and Two Months Estimated Operating Expenses

In accordance with 765-1.2(b)(3), all LHCSA applicants are subject to a financial review which includes an examination of the sources of available working capital, with a minimum requirement equal to at least two months of estimated operating expenses of the agency.

To comply with this requirement, a written plan and financial review of available resources must be submitted.

Written Plan

1. Provide a written summary that identifies all funding sources to be utilized to support the agency for at least two months after licensure. The amount of working capital to be utilized must be clearly specified.

2. Include a chart or written description of the projected operating costs during the first two months after licensure. Expenses include, but are not limited to salaries, office space, utilities, supplies and miscellaneous operating costs.

TIP: The expenses must be reasonable and will be evaluated by DOH.

TIP: The application must pass a reasonableness test with respect to the financial capability of the LHCSA or sources for start-up funding.

TIP: DOH will examine the LHCSA's financial feasibility or projections indicating that the LHCSA's revenues, including but not limited to operating revenue, will be equal to or greater than projected expenditures over time.

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Section G: Financial Resources (cont'd)

<u>Financial Review</u>

- If the applicant intends to utilize existing financial resources (savings, investments, approved loan or awarded grant, etc.), a Certified Public Accountant (CPA) must evaluate the amount of working capital available to the applicant. The entity's most recent Balance Sheet and written confirmation provided by a CPA on letterhead must be included with the application.
- If the applicant intends to provide working capital by equity contributions, Personal Financial Statements must be submitted for each member contributing equity, including for any member which is not a natural person. These document(s) must be on CPA letterhead, signed and dated by each member shareholder and be included with the application.
- If funding will be provided by a related and/or parent organization, the applicant must provide a letter from that entity's CPA, which confirms the amount of funding to be provided. The most recent Balance Sheet by the funding entity must be submitted with the application.

<u>TIP</u>: A loan or grant will only be considered working capital if the award was made prior to or at the time of application and supportive documentation is submitted. Prospective funding sources will not be considered.

<u>TIP</u>: Personal financial statements must be based on the most current information available and cannot be more than 6 months old unless accompanied by a current no material change affidavit.

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Section G: Financial Resources (cont'd)

I have included a Written Plan and Financial Review document(s) with my application:

□ Yes □ No

If yes, Attachment # Financial .

Please name the attachment 'Financial'.

Part 2 – Projected Operating Costs

In accordance with 765-1.2(b)(3), all LHCSA applicants are subject to a financial review which includes an examination of the financial feasibility of the agency or projections indicating that the agency's revenue, including but not limited to operating revenue, will be equal to or greater than projected expenditures over time.

To comply with this requirement, the following must be submitted by each applicant:

Instructions: All applicants must submit the First and Third Year Operating Cost columns. Change of Ownership applicants must also complete the Current Operating Costs column for the agency being acquired. If multiple agencies are being acquired, attach additional charts for each LHCSA.

Section G: Financial Resources (cont'd)

- **Table G1: Summary of Operating Costs**

Costs	Current Operating Costs (If Applicable)[1]	Estimated Operational Costs: First Year	Estimated Operational Costs: Third Year
Director/Administrator			
Supervisors			
Nurses (RNs/LPNs)			
Home Health Aides			
Personal Care Aides			
Homemakers/Housekeepers			
Professional Staff			
Clerical Staff			
Other Staff			
Employee Benefits			
Space Occupancy (Rent/Utilities)			
Office Supplies			
Contract Services			
Transportation			
Medical and Nursing Supplies			
Other (Please Specify)			
Total			

(1) The Department may require the agency(ies) being acquired to submit a written attestation of current operating costs.

Authorized Signature

Name of Applicant: ________________________________

According to Article 36 of the Public Health Law, a home care services agency subject to licensure is an organization engaged in arranging and/or providing, either directly or through contract arrangement, nursing, home health aide or personal care services.

Please confirm the following by signing in the space provided below:

- The applicant is not providing home health aide or personal care by referral, contract or directly at the current time.
- The applicant is not providing registered nurse or licensed practical nurse services in the home at this time outside of that provided as an individual practitioner within the scope of their license.
- Regardless of the title of the workers, the applicant is not providing any individuals, either directly, by contract, or through referrals that deliver “hands on” personal care services to patients in their home.
- The applicant is aware that they may not commence operation of the home care agency until after the application has been approved by the Public Health and Health Planning Council and the agency has obtained a license from the Department of Health. Once licensed, a license is not transferrable. A new application and approval must be granted before a change in owner or operator occurs.

Authorized Signature: ________________________________ Date: __________________

Print Name: ____ Title: ___________________________

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