



Division of Quality Assurance  
**Residential Care Facility**  
**Change of Operator Application Instructions**

**General Information and Instructions**

A Change of Operator Licensure application must be submitted at least 30 days in advance of the proposed change. An Ohio Department of Health (ODH) inspection may be required if your facility has not been inspected within the past 15 months or the facility was cited for serious health or safety deficiencies on the most recent survey.

**A check or money order, made payable to the Treasurer, State of Ohio in the amount of \$320 for each 50 beds or part thereof must accompany your application. See example below.**

1 - 50 beds	\$320
51 - 100 beds	\$640
101 - 150 beds	\$960
151 – 200 beds	\$1,280
201 – 250 beds	\$1,600
251 – 300 beds	\$1,920

**Required Documents:**

The following documents must be submitted with your “Nursing Home/Residential Care Facility Licensure Application” and fee:

1. 8 ½" x 11" schematic drawing (floor plan) of the facility that clearly shows the bath/toilet rooms, room numbers and number of beds in each room
2. A copy of the facility's Certificate of Occupancy permit
3. A copy of the facility's current central heating inspection report
4. A copy of the facility's current State Fire Marshal Inspection report documenting that the facility is in compliance with the state fire code
5. A copy of the bill of sale

**Application Submission:**

Submit the completed change of operator application form, check or money order in the correct amount, and the required documents listed above to the following address:

Ohio Department of Health  
Revenue Processing #3212  
PO Box 15278  
Columbus, Ohio 43215

If the application is incomplete or is not accompanied with the fee and required documents listed above, licensure approval may be delayed, your application may be returned to you or your application may be denied. Deposit of your fee does not mean that your application has been accepted and/or declared complete.

**Questions:**

If you have any questions regarding your nursing home change of operator application, please e-mail the Licensure Program in the Division of Quality Assurance, Ohio Department of Health at [liccert@odh.ohio.gov](mailto:liccert@odh.ohio.gov) or call (614) 466-7713.





# Ohio

Department of Health

11. Individual Operator

Operator's Name		
Address		
City	State	Zip

12. Business Operator – Association, Corporation, Limited Liability Company, Partnership

Operator's Business Name			
Address			
City	State	Zip	Phone #
Business activity type	Charter/Registration #		Date incorporated

13. Business Operator officers/members/partners

President	Member	Partner
Vice President	Member	Partner
Secretary	Member	Partner
Treasurer	Member	Partner

14. Name of each person who has ownership interest of 5% or more in the Operator's business entity

Name	Name

15. Statutory agent of the operator (As Registered with the Secretary of State)

Name of Statutory Agent of Operator			
Address			
City	State	Zip	Phone #



# Ohio

## Department of Health

16. If the Operator does not own the legal rights associated with the ownership and operation of the nursing home beds, enter the name of each person who has an ownership interest of 5 percent or more in the nursing home beds

Not applicable

Name	Name

17. Statutory Agent of the owner of the legal rights associated with the ownership and operation of the nursing home beds

Not applicable

Name of Statutory Agent of Owner of the Nursing Home Beds			
Address			
City	State	Zip	Phone #

18. Does the operator own the building housing this long-term care facility?  Yes  No

If no, name of business entity that owns building and each person who has an ownership interest of 5 percent or more in the building and an address for building owner.

Business Entity Name			
Address	City	State	Zip
Name	Name		
Name	Name		
Name	Name		

19. Loan Information

Does Operator or Building Owner have a loan with the United States Housing and Urban Development (HUD) for this home?
<input type="radio"/> Yes, Name of Entity with HUD Loan <input type="radio"/> No

20. Management firm or business employed to manage this long-term care facility.  Not applicable

Management firm/business name			
Address			
City	State	Zip	Phone #



# Ohio

## Department of Health

21. Name and address of any nursing home or any facility described in 3721.01(A)(1)(a) or (A)(1)(c) of the Revised Code in which the operator or administrator, or both, have an ownership interest of 5 percent or more or with which the operator (including owners of 5 percent or more in the Operator entity) or administrator have been affiliated with through ownership or employment in the five years prior to the date of the application.

Name	Address

22. Additional Questions

	Yes	No
Have you or any partner, member or officer listed in this application been convicted of a felony or a crime of moral turpitude?	<input type="radio"/>	<input type="radio"/>
Are you or any member, partner or officer listed of this facility engaged in practices that could be construed as immoral?	<input type="radio"/>	<input type="radio"/>
Is there any reason why this facility will not be able to operate for the next 12 months?	<input type="radio"/>	<input type="radio"/>

If you or any partner or officer has answered "YES" to the questions above, please attach a separate document explaining.

23. **SPECIALIZED CARE PROGRAM** - Check what specialized care or services your facility provides:  N / A

<input type="checkbox"/>	Coma treatment	<input type="checkbox"/>	Respirator or ventilator care	<input type="checkbox"/>	Specialized Alzheimer's Disease
<input type="checkbox"/>	Neurological injury program for young adults	<input type="checkbox"/>	Traumatic brain injury program	<input type="checkbox"/>	Deaf or hearing impaired
<input type="checkbox"/>	Pediatric care	<input type="checkbox"/>	Amyotrophic lateral sclerosis	<input type="checkbox"/>	Adult day care program
<input type="checkbox"/>	Dialysis services	<input type="checkbox"/>	Hospice services	<input type="checkbox"/>	Other:

ATTESTATION

I, the undersigned, attest that:

- Operator has sufficient capital or financial reserve to cover not less than four months' operation and is financially able to operate the home in accordance with Chapter 3721. of the Revised Code and the applicable rules of the Ohio Administrative Code;
- Home is staffed, equipped and furnished to provide humane, kind and adequate treatment and care; and
- Home is in compliance with applicable zoning ordinances and rules.

By affixing my signature immediately below, I acknowledge awareness:

- Of the provisions of the Revised Code that provide that any person who knowingly makes a false statement or knowingly swears or affirms the truth of a false statement previously made when the statement is made with purpose to secure the issuance by a government agency of a license is guilty of falsification, a misdemeanor of the first degree (section 2921.13(A)(5) and (D)) of the Revised Code. A misdemeanor of the first degree is punishable by fine and/or imprisonment as provided in section 2929.21 of the Revised Code.
- That failure to timely provide all of the required information to the Ohio Department of Health will delay the on-site licensing inspection and issuance of my license, or void my application as being incomplete.
- That I cannot operate the home or admit more than two residents until I have been determined to be in compliance with the applicable licensing law and rules and have received my license.



# Ohio

Department of Health

I swear or affirm that the undersigned is:

- The operator, if the operator is an individual, or
- A duly authorized agent of the operator, if the operator is an association, partnership, limited liability company or corporation.

I further swear or affirm that the information provided herein, and any attachments hereto, have been prepared, or carefully reviewed, by me and constitute a truthful and correct disclosure of all information therein.

Name of undersigned:

Title:

Signature:

Date: