



Office of Health Facilities

Application for Change of Ownership

Reference Guide for New Applicants

Let's begin!

Log In to the Platform

1 Enter your username and password.

2 Click the Log In button.

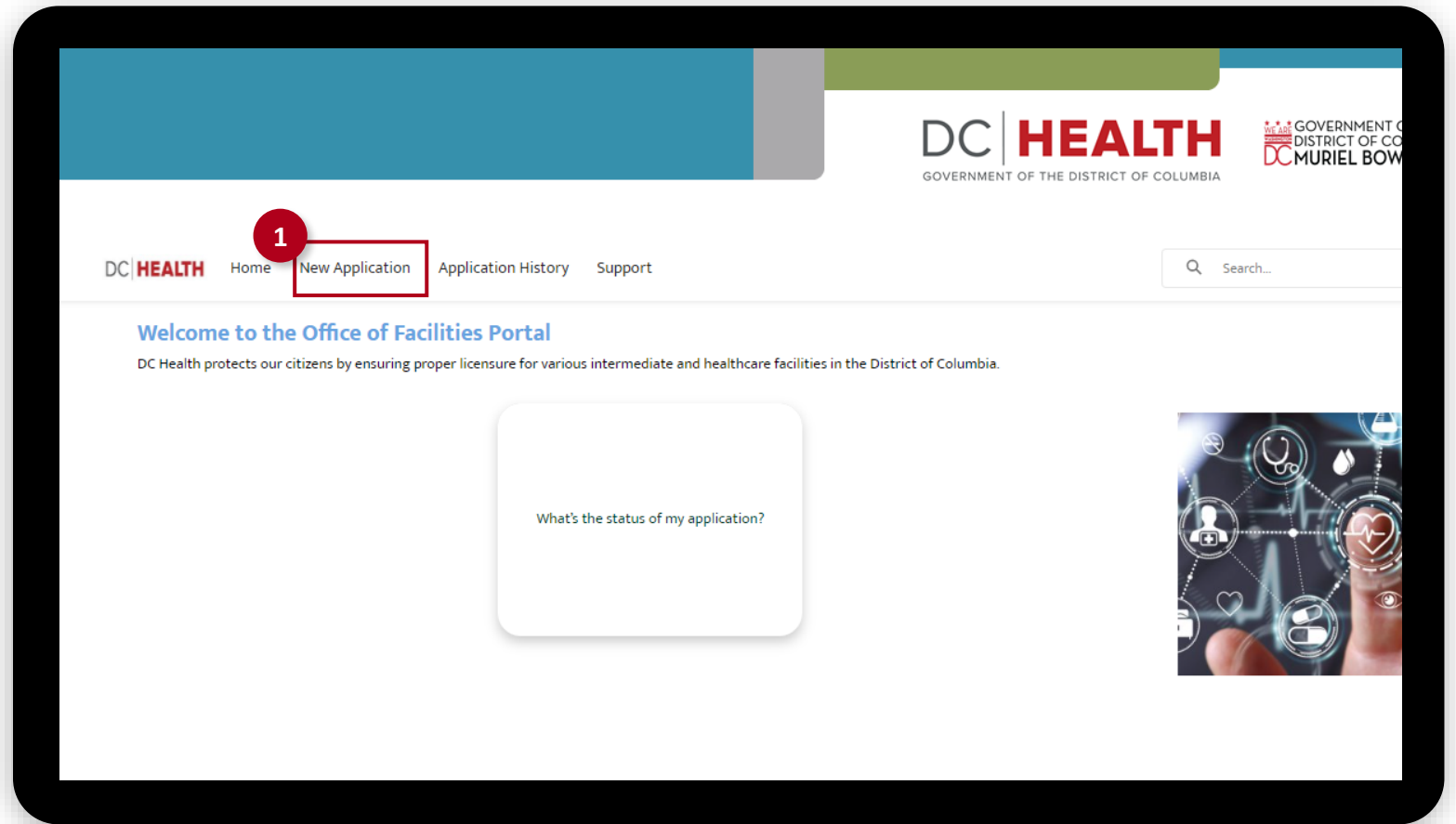


TIP: If you don't have an account click the **Create New Account** link.

The screenshot shows the DC Health login interface. At the top right, the DC Health logo and the Government of the District of Columbia logo with Mayor Muriel Bowser's name are visible. The main content area features the DC Health logo, a welcome message, and a login form. The login form has two input fields: the first contains 'TestUser17' and the second contains a masked password '.....'. Below the password field is a blue 'Log in' button. A red box highlights the entire login form area, with a red circle containing the number '1' next to the username field and a red circle containing the number '2' next to the password field. Below the login form are links for 'Forgot your password?' and 'Forgot username?'. To the right of the login form is a 'Create New Account' link. Further right, there is a 'Welcome to the Office of Health Facilities Portal' section with a brief description and a list of actions: 'Apply for a new medical facility license', 'Renew an existing medical facility license', 'Check the status of past applications', and 'Seek support related to interactions with this office'. Below that is an 'About DC Health' section with a paragraph of text.

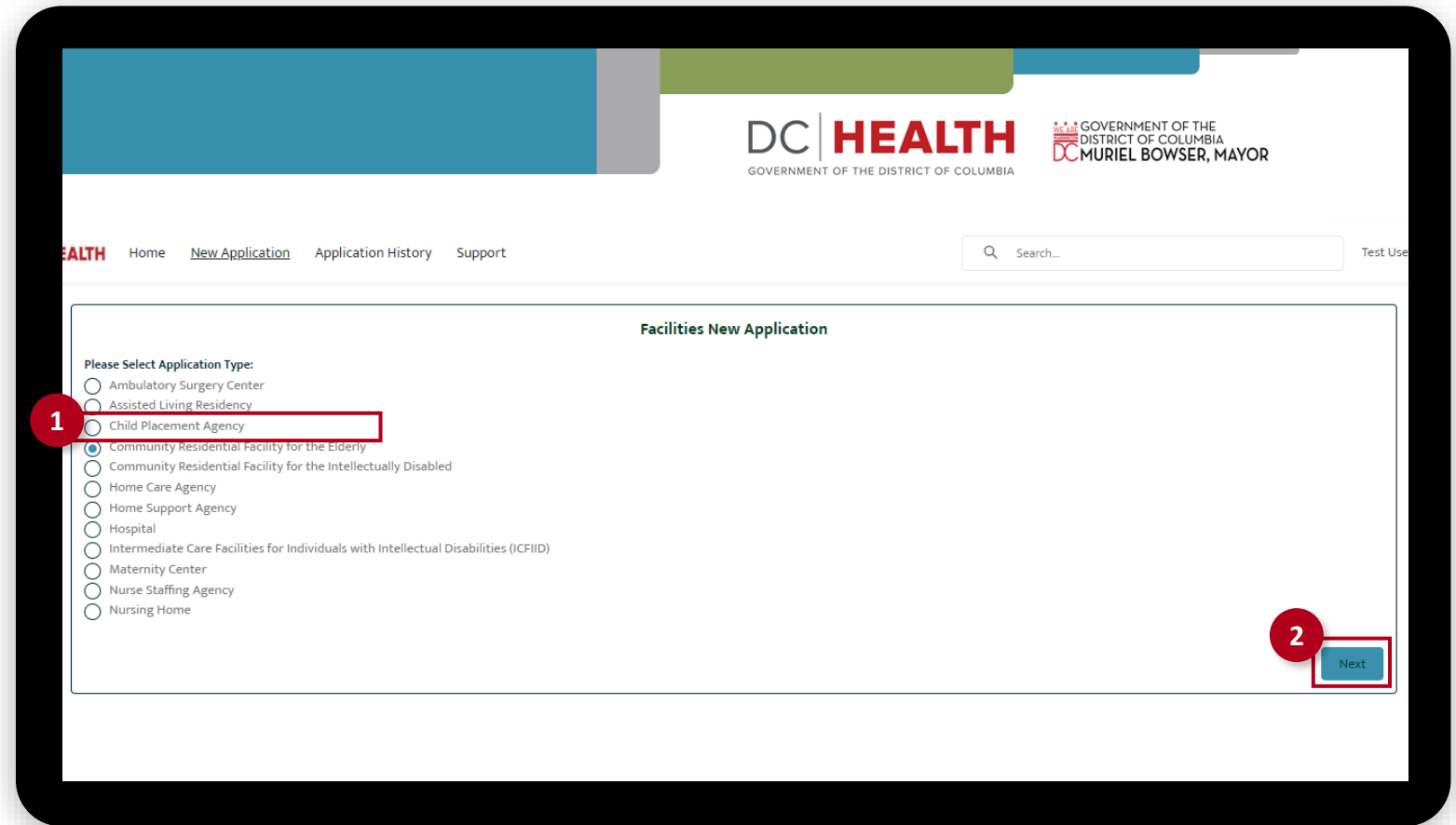
Navigate to the New Application Screen

- 1 Once you Log in to the Office of Facilities Portal, click the **New Application** tab.



Select the Application Type

- 1 Select the appropriate option from the list.
- 2 Click the **Next** button.



Select the Application Sub Type

- 1 Select the **Change** option from the drop-down list.
- 2 Click the **Save & Next** button.



Enter License Number

The licensee is the legal entity who has the ultimate responsibility and authority for the conduct of the facility.

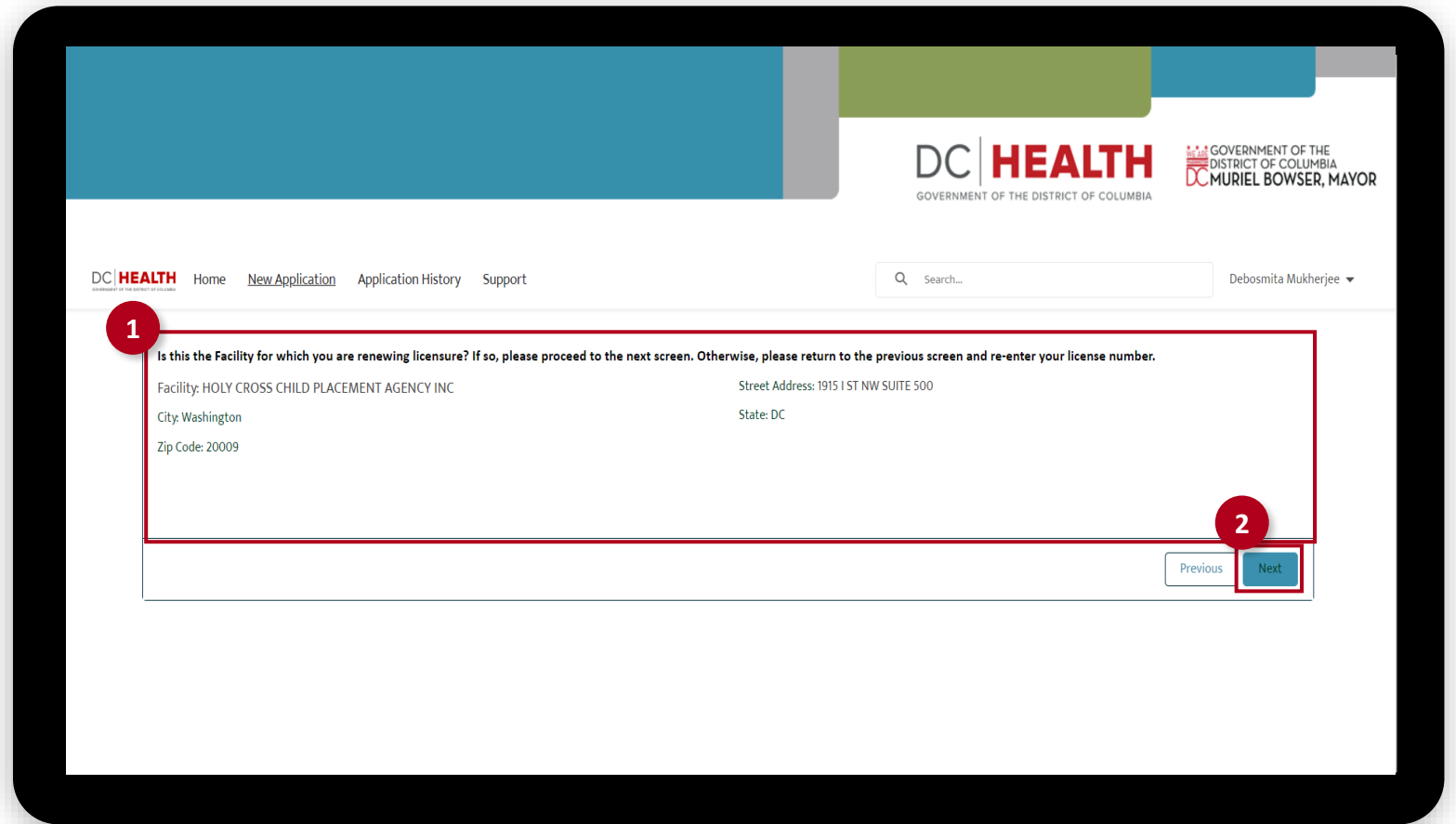
- 1 Enter your license number in the License Number field.
- 2 Click the Next button.

The screenshot shows a web application interface for DC Health. At the top right, there are navigation arrows. The header includes the DC Health logo and the Government of the District of Columbia logo with Mayor Muriel Bowser's name. Below the header is a navigation menu with links for Home, New Application, Application History, and Support. A search bar and a user profile dropdown (Debosmita Mukherjee) are also present. The main content area features a form titled 'License Number' with a mandatory field containing 'CPA-023'. A red circle with the number '1' highlights the input field. At the bottom right of the form, there are 'Previous' and 'Next' buttons, with a red circle and the number '2' highlighting the 'Next' button.

The fields marked with * are mandatory and must be filled out to continue.

Verify the License Information

- 1 Verify the details of the license.
- 2 Click the **Next** button.




The fields marked with * are mandatory and must be filled out to continue.

Select the Changes

- 1 Check mark the **Change of Ownership** option from the list.
- 2 Click the **Save & Next** button.

The screenshot shows a web application interface for DC Health. At the top right, there are navigation arrows. Below the header, the DC Health logo and the Government of the District of Columbia logo with Mayor Muriel Bowser's name are visible. A navigation menu includes 'Home', 'New Application', 'Application History', and 'Support'. A search bar and a user profile 'Debosmita Mukherjee' are also present. The main content area is titled 'Change Type' and contains a mandatory question: '*What change(s) would you like to submit? Please Select All That Apply:'. There are three checkboxes: 'Change of Address', 'Change of Name', and 'Change of Ownership'. The 'Change of Ownership' checkbox is checked and highlighted with a red box and a '1' in a red circle. At the bottom right of the form, there are two buttons: 'Previous' and 'Save & Next'. The 'Save & Next' button is highlighted with a red box and a '2' in a red circle.

 **TIP:** If you need to make multiple changes, check mark all that apply from the list.

*The fields marked with * are mandatory and must be filled out to continue.*

Fill in the New Owner Information

- 1 Fill in relevant details under the new owner section.
- 2 Click the Save & Next button.

Ownership Change

Please enter the following contact information for the NEW owner.

1

* First Name Pearl	MI Andrew	* Last Name Goodwin
* City North Aaronview	* Street Address 4G, 101 Street, 4th Avenue	
* Zip Code 53761	* State ID	
* Email Pearl@fakedata.com	* Phone 597-557-3241	
* What is the anticipated date of ownership transition? Apr 18, 2023		

2 Save & Next

Verify Agency Information

- 1 Verify the contact details of the Agency Information.
- 2 Click the Save & Next button.

The screenshot shows a form titled "Agency Information:" with a red border. A red circle with the number "1" is positioned at the top left of the form. The form contains the following fields:

- * Name: HOLY CROSS CHILD PLACEMENT AGENCY INC
- * Street Address: 1915 I ST NW SUITE 500
- * City: Washington
- * State: DC
- * Zip Code: 20009
- * Telephone Number: 202-332-1367
- * Fax Number: 1234566543
- * Business After-Hours Number: 9098765432
- * Email: data@verify.com

At the bottom right of the form, there is a "Save & Next" button highlighted with a red box and a red circle containing the number "2".

Verify the Executive Director Information

- 1 Verify the contact details of the Executive Director Information.
- 2 Click the Save & Next button.

The screenshot shows a web form titled "Executive Director Information:" with a red border. A red circle with the number "1" is in the top left corner of the form. The form contains the following fields:

- * First Name: Garland
- Middle Name: Elige
- * Last Name: Turner
- * Street Address: 784 Maryse Village
- * City: New Alessia
- * State: MT (dropdown menu)
- * Zip Code: 61117
- * Telephone: 367-987-8046
- * Highest Level of Education Completed: Thiel - Morisette
- * Email: your.email+fakedata59151@gmail.com

At the bottom right of the form, there is a "Save & Next" button highlighted with a red box and a red circle containing the number "2".

Fill in the Applicant Information

1 Fill in the Applicant Information.

2 Click the Save & Next button.

1 Applicant Information:

* First Name: Alexis Middle Name: Last Name: Maggio

* Street Address: 140 Jerde Hills

* City: New Annamedio * State: KS

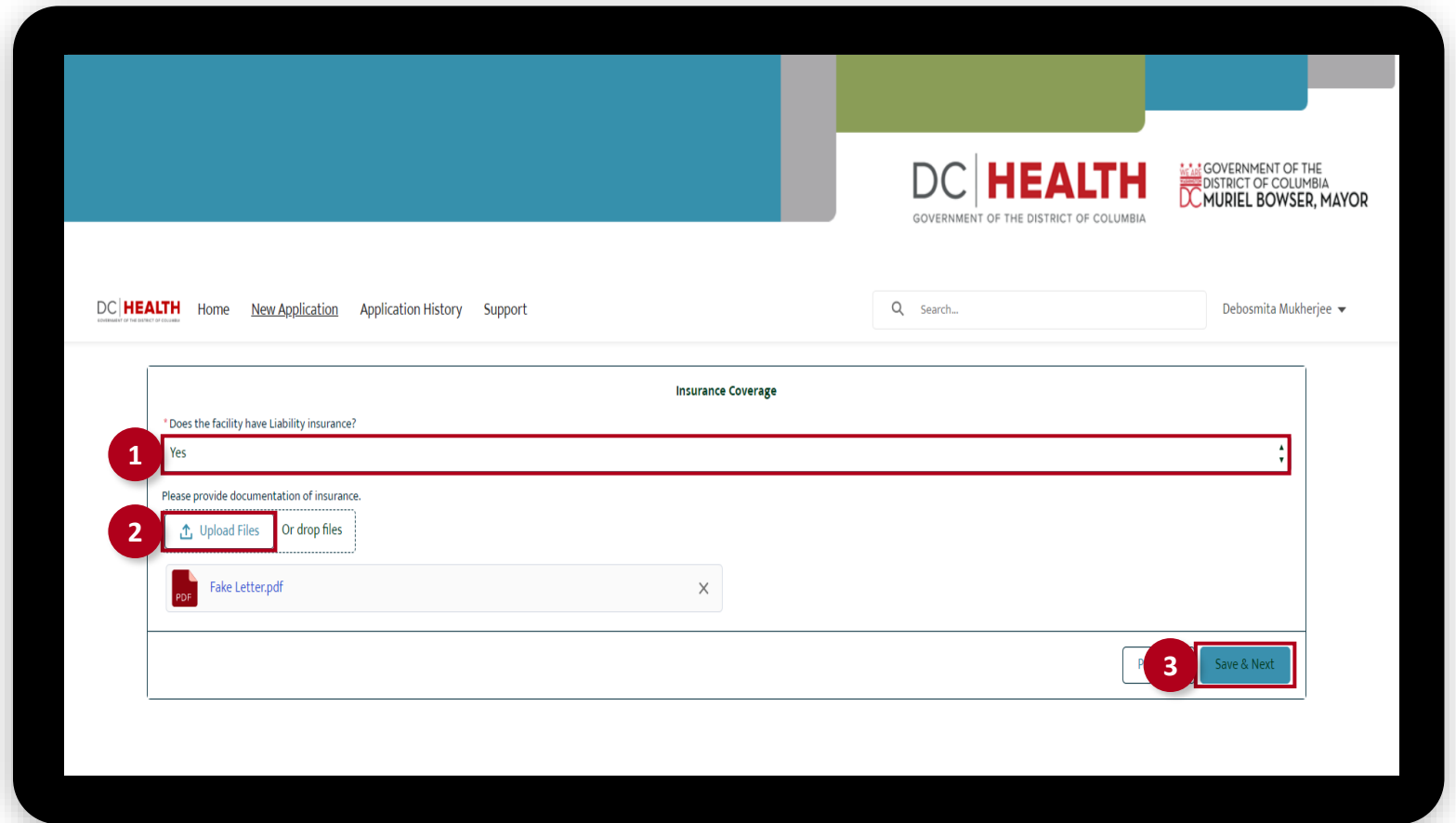
* Zip Code: 309090 * Telephone: 894-774-5689

* Email: Alexis@fakedata.com * Relationship of Applicant(s) to Child Placing Agency: 82 Zieme Point

2 Save & Next

Upload the Insurance Coverage Details

- 1 Select the **Yes** option from the list.
- 2 Upload the formal letter from the provider in pdf format only.
- 3 Click the **Save & Next** button.



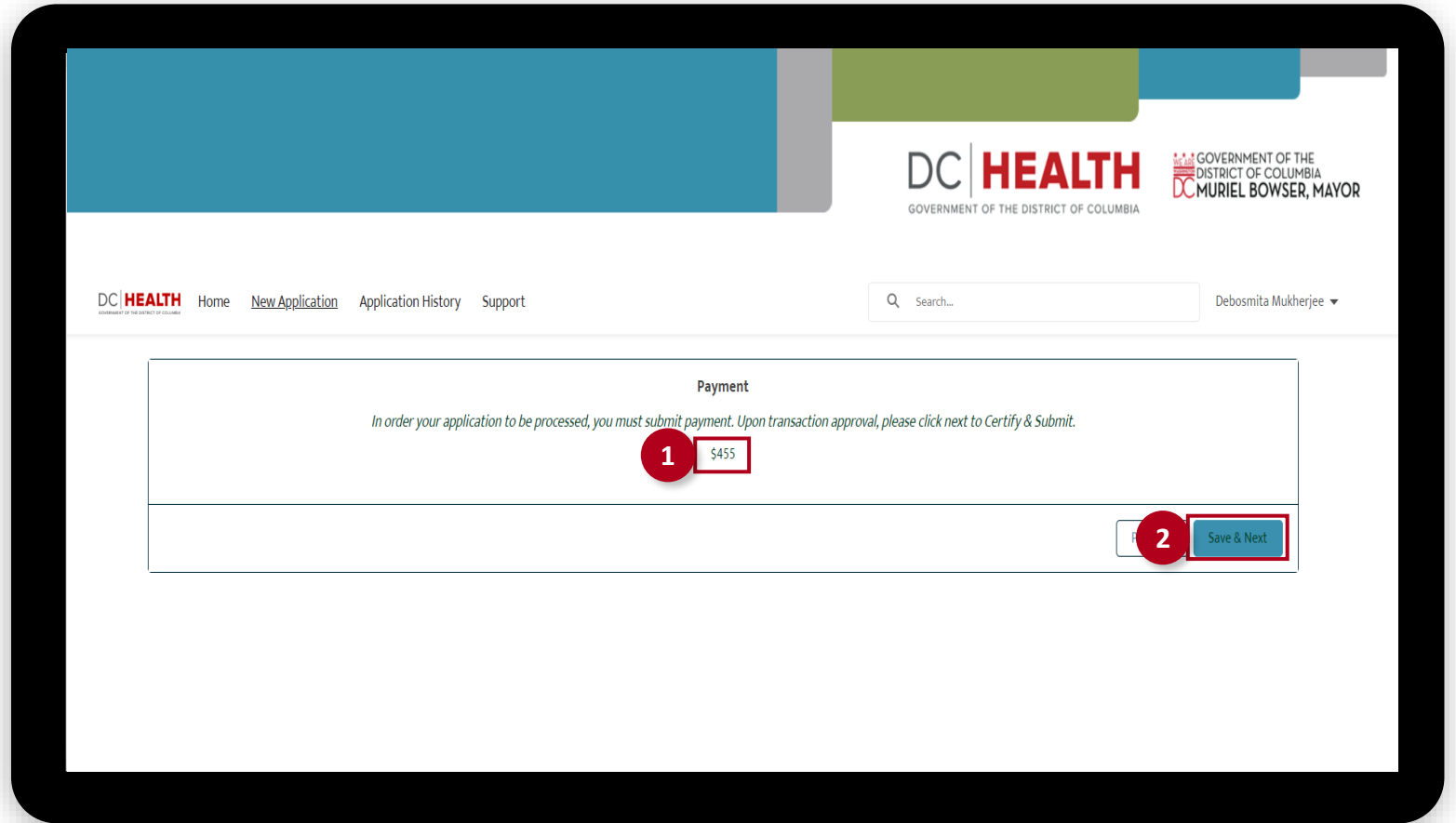
Upload the Supporting Documents

- 1 Upload the supporting documents to the Insurance Coverage.
- 2 Click the **Save & Next** button.

The screenshot shows a web form titled "Required Forms" with the instruction: "*Please upload the following supporting documents." Below this, a list of required documents is provided: Bill of Sale/Asset Purchase Agreement, Certificate of Need Approval (letter) from the DC Health State Health Planning and Development administration authorizing the CHOW, COO - certificate of occupancy, OCR form [office of civil rights], Bill of Sale/Asset Purchase Agreement, CMS Form 855Bs - Medicare enrollment application, Fiscal Intermediary contact information, CMS Form 1561 (Health Insurance Benefits Agreement), DOH application for Licensure [include attachments], and CMS 377 - ASC request for initial certification/update. At the bottom left, there is an "Upload Files" button with an upward arrow icon and a dashed box labeled "Or drop files". A red circle with the number "1" is placed over this button. At the bottom right, there is a "Save & Next" button. A red circle with the number "2" is placed over this button.

Verify the Fee Details

- 1 Verify the fee details.
- 2 Click the Save & Next button.



Payment Wizard



1 Fill out the **Billing Address** and **Payment Info** fields.

2 Click the **Pay** button.

DC HEALTH Home [New Application](#) Application History Support

Sequi voluptas maiores nam. Test Users5

Payment Wizard

Please complete the payment for your application using the form below. Click "Pay" when you are done inputting your payment details. If you are unable to pay at this time, you may exit this saved draft and return to it in the "Application History" tab of the portal header later.

After your payment has processed, click "Next" below to certify and submit the application. Your application will not be reviewed until these steps have been completed.

1

Billing Address	Payment Info
2879 Ortiz Crest	Solon Miller
788 Gottlieb Pass	3782 822463 10005
Fort Joan	09 / 25
Oregon ?
16913-4451	

2 Pay \$390.00

Click the Next button at the bottom of this page to Certify & Submit the application.

Previous Next

Fill out the Principals/Officers Information

- 1 Fill out all the required fields.
- 2 Click the **Save & Next** button.

HEALTH Home [New Application](#) Application History Support

Et sunt sunt dolor distinctio et facere maxime aut maxim Test Users

Name the principals/officers of the licensee: (such as, CEO, President, VP, Secretary, Treasurer, Director)

1 Principal/Officer of the Licensee - 1

* First Name Middle Name * Last Name
Brittany Lavinia Hudson Dibbert

* Street Address * City
29299 Alva Shore Daniellastead

* State * Zip code
AK 20001

* Telephone Number * Email
172-865-5359 your.email+fakedata39187@gmail.com

* Title
Doctor

Add more Principal/Officers?

2 Save & Next



TIP: If you need to add multiple Principals/Officers, select the **Add more Principal/Officers?** box.

The fields marked with * are mandatory and must be filled out to continue.

Fill out the Facility Staffing Information

1 Fill out all the required fields.

2 Click the Save & Next button.

The screenshot shows a web form titled "Facility Staffing" with a red border. A red circle with the number "1" is in the top-left corner of the form area. The form contains several sections and fields:

- Residence Director:**
 - * Prefix: Mr. (dropdown)
 - * Name: Samir Maggio
 - * Title: Legacy Mobility Executive
 - * Highest Level of Education Completed: Veum LLC
 - * Name of Qualified Mental Retardation Professional (QMRP): Margarita O'Connell
- Other Professionals on Staff, if applicable:**
 - Director of Nursing:** Name: Tad Gusikowski
 - Primary Care Physician(s):** Name: Elouise Hoeger
 - Licensed Practical Nurse(s):** Name: Stanton Becker
 - Trained Medication Employee(s):** Name: Alexys Pfeffer
 - Live-In Staff:** Name: Jarvis Sipes

At the bottom right of the form, there is a "Save & Next" button highlighted with a red circle and the number "2".

The fields marked with * are mandatory and must be filled out to continue.

Fill out the Insurance Coverage Information

- 1 Fill out all the required fields.
- 2 Click the **Upload Files** button if needed to attach relevant documents.
- 3 Click the **Save & Next** button.

Insurance Coverage

Attach documentary evidence of financial responsibility on the part of the applicant as stipulated below

1 Hazard (Fire and extended coverage) Minimum of \$500 per resident or \$2000 per facility

* Agency Name Onie Bergnaum	* Street Address 5538 Heidenreich Island
* City Jaquanton	* State NH
* Zip Code 20001	* Hazard Amount of Coverage 500

Liability Insurance - Minimum of \$300,000 per occurrence

* Agency Name Faustino Pfeffer	* Street Address 18877 Herminia Hill
* City New Dallasfield	* State SC
* Zip Code 20001	* Liability Amount of Coverage 300,000

* Professional Liability (Explain)
Consequuntur culpa sunt repudiandae neque repellendus aspernatur.

2 Upload Files Or drop files

3 Save & Next

The fields marked with * are mandatory and must be filled out to continue.

Payment Wizard



- 1 Once the Transaction is approved, click the **Next** button.

The screenshot displays the DC Health website's Payment Wizard. At the top, the navigation bar includes 'DC HEALTH', 'Home', 'New Application', 'Application History', and 'Support'. A search bar contains the text 'Sequi voluptas maiores nam.' and the user is identified as 'Test Users5'. The main content area is titled 'Payment Wizard' and contains the following text: 'Please complete the payment for your application using the form below. Click "Pay" when you are done inputting your payment details. If you are unable to pay at this time, you may exit this saved draft and return to it in the "Application History" tab of the portal header later.' Below this, it states: 'After your payment has processed, click "Next" below to certify and submit the application. Your application will not be reviewed until these steps have been completed.' A large modal window is centered on the screen, featuring a green checkmark icon and the text 'Transaction approved'. The background shows a form with fields for 'Billing' (2879 Ortiz Crest, 788 Gottlieb Pass, Fort Joan, Oregon, 16913-4451) and 'Info'. A 'Pay \$390.00' button is visible in the bottom right of the form area. At the bottom of the wizard, there are 'Pay' and 'Next' buttons. A red circle with the number '1' highlights the 'Next' button, and a red line points to it from the instruction below: 'Click the Next button at the bottom of this page to Certify & Submit the application.'

Certify and Submit

1 Fill out the **Name** and **Date** fields.

2 Click the **Submit** button.



TIP: The date should correspond to the date you fill out and complete this form.

HEALTH Home [New Application](#) Application History Support

Soluta a animi magni quo aliquid voluptatem. Test User

Certify and Submit

By clicking the submit button below, you are acknowledging that you are providing information for an official record and that the information you are supplying is true. By submitting this information, you understand that knowingly and willfully making a false statement on an official record may result in action against your license, registration, or certification and criminal penalties*. This information will be held confidential by the Department of Health.

*(a) A person commits the offense of making false statements if that person willfully makes a false statement that is in fact material, in writing, directly or indirectly, to any instrumentality of the District of Columbia government, under circumstances in which the statement could reasonably be expected to be relied upon as true; provided, that the writing indicates that the making of a false statement is punishable by criminal penalties or if that person makes an affirmation by signing an entity filing or other document under Title 29 of the District of Columbia Official Code, knowing that the facts stated in the filing are not true in any material respect or if that person makes an affirmation by signing a declaration under § 1-1061.13, knowing that the facts stated in the filing are not true in any material respect;

(b) Any person convicted of making false statements shall be fined not more than the amount set forth in § 22-3571.01 or imprisoned for not more than 180 days, or both. A violation of this section shall be prosecuted by the Attorney General for the District of Columbia or one of the Attorney General's assistants.

By electronically entering my name on this form, I attest that all statements are true and accurate.

*Name
Waylon Hyatt

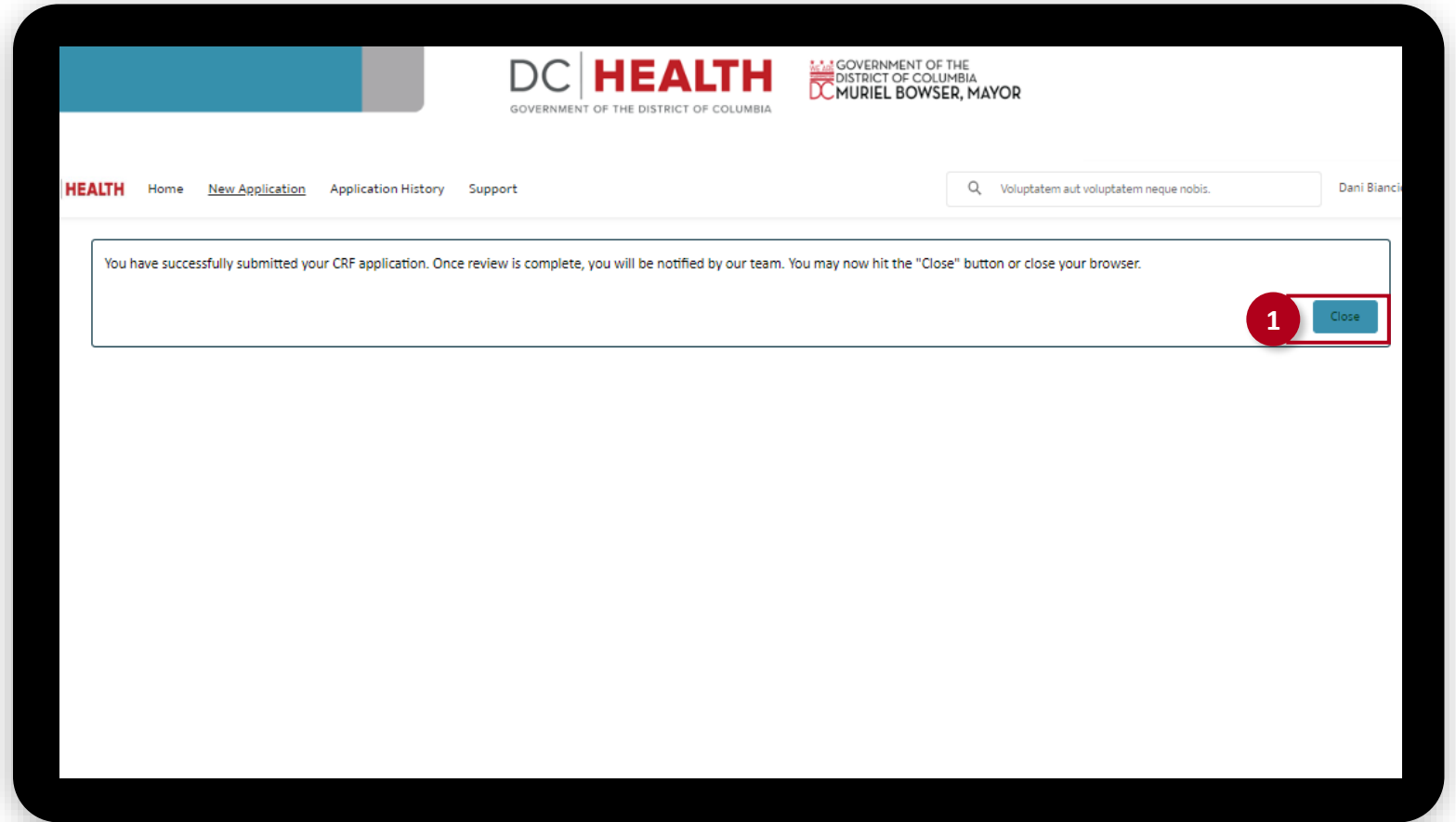
*Date
Oct 4, 2022

Submit

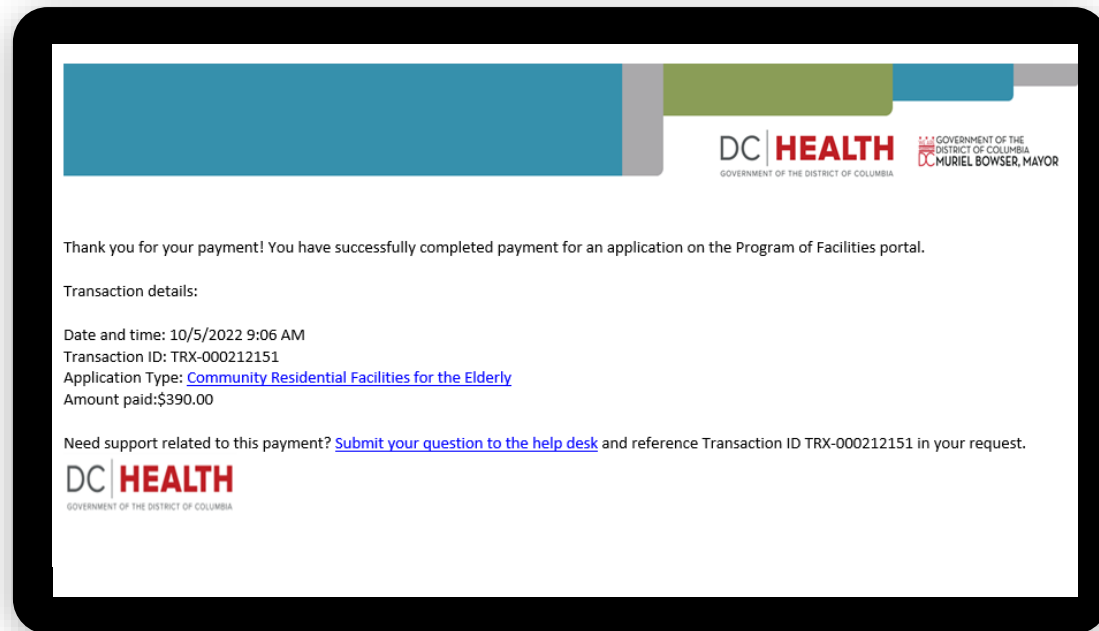
*The fields marked with * are mandatory and must be filled out to continue.*

Close the Application

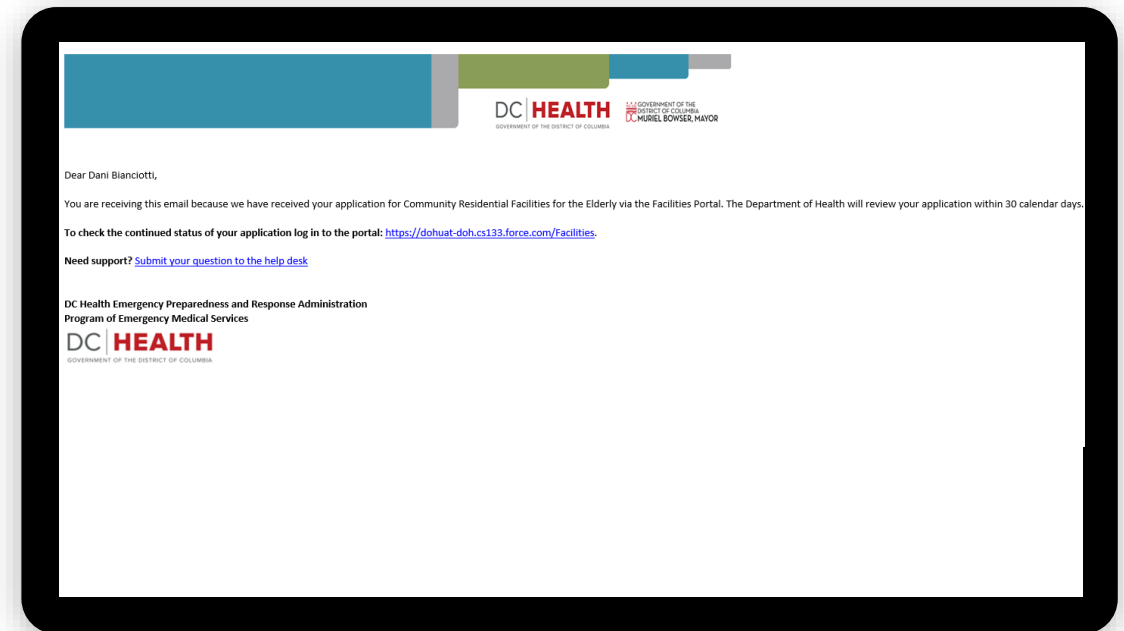
- 1 You have finished submitting your application. Click the **Close** button.



E-mail Confirmation



1 Check if you have received confirmation of payment.



2 Check if you have received confirmation for your application.

Thank you!