Appendix I

MISSISSIPPI STATE DEPARTMENT OF HEALTH

TRANSFER COUNTY OF A HOME HEALTH AGENCY

(Must be accompanied by processing fee $.25 of 1% of cost)

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