Attachment A
LHCSA Administrative Licensure Amendment
Request Checklist

EMAIL THIS CHECKLIST WITH REQUIRED DOCUMENTS TO:
LHCSA-Amend@health.ny.gov

Agency Name:_____ **License #**_____

Agency Contact Person:_____

Phone:_____ **Email:**_____

Name of Agency Operator:_____

Phone: _____ **Email:**_____

☐ A written request on agency letterhead signed by the administrator or a letter from the agency's counsel, or a consultant on behalf of the agency. **Required**

Delete/Add Service

☐ New service(s) to be added: *If yes, include all the following*:
- ☐ Policy and Procedures for new service(s)
- ☐ Job description of staffing for the new service(s)
- ☐ Annual evaluation tool for new service(s)

☐ Service(s) to be deleted. *If yes,*
Indicate the number of patients receiving service(s) proposed to be deleted or indicate none. *If a patient is receiving service(s) proposed to be deleted, select the box below:*
- ☐ Include a plan on how each patient will be transitioned to another provider that addresses maintenance and safekeeping of patient records, as well as a complete list ofalternate providers.
- ☐ Include a copy of the letter that will be provided to the patients and/or their families, notifying them of the discontinuation of the service(s) and providing them with a list of available LHCSA providers for that county that offer the service being discontinued.

Delete/Add County

☐ New county to be added: *If yes,* Name of County: _____
- ☐ Description of request, including staffing plan.
- ☐ Check here if the request is to exclusively serve an ALP, CCRC, PACE, or NFP program.
- ☐ Current number of patients being served in each approved county currently on their license.

☐ County(ies) to be deleted: *If yes,*
- ☐ Indicate the number of patients receiving service(s) in the county to be deleted or indicate none.

If a patient is receiving service(s) in a county to be deleted, select the box below:
- ☐ Include a plan on how each patient will be transitioned to another provider that addresses maintenance and safekeeping of patient records, as well as a complete list of alternate providers.
- ☐ Include a copy of the letter on agency letterhead and signed by the Administrator or Operator that will be provided to the patients and/or their families, notifying them of the discontinuation of services and providing them a list of available providers for that county.

☐ Adding an Additional Site: *If yes, include all the following*:
- ☐ List the new address, telephone, and facsimile number(s), and email address(es), if applicable.
- ☐ Indicate the proposed effective date of the site operation.
- ☐ List each county requested to be included in the service area and indicate if they are counties currently on license or if concurrently applying to add them to the license.

- ☐ Indicate the proposed services to be provided at the new site if approved.
- ☐ Provide the executed lease agreement, certificate of occupancy, and floor plan/diagram.

☐ Change of Address of an Agency of Operator: *If yes, include all the following*:

- ☐ Indicate whether the proposed change applies to the agency, operator, or both.
- ☐ List the new address, telephone, and facsimile numbers, and new email address(es), if applicable.
- ☐ Indicate the proposed effective date of the location change.
- ☐ Provide the executed lease agreement, certificate of occupancy, and floor plan/diagram.

Change of Name (Note: Part 2 of the process will commence upon approval of Part 1)

Part 1

☐ New or changed assumed name: *If yes,*

- ☐ Submit the proposed Certificate of Assumed Name and/or proposed Certificate of Discontinuation of Assumed Name for the previous assumedname, as applicable.
- ☐ Provide the current and proposed names and an explanation of the nature of, and the reason(s) for the requested name change.

☐ Legal Entity (LLC/Corporate/NFP) name change: *If yes,*

- ☐ Proposed Certificate of Amendment of the legal entity's formation document, as appropriate.
- ☐ Provide the current and proposed names and an explanation of the nature of, and the reasons for, the requested name change.

☐ License Reprint Requested

Please note that the Department reserves the right to seek additional information from the operating entity in order to render a determination for the decision of an administrative licensure amendment request.

Please also note that not all changes to the LHCSA license are handled through this administrative process. Any changes in ownership and control of the LHCSA pursuant to Public Health Law §3611-A and 10 NYCRR §765-1.12 to 10 NYCRR §765-1.14 require the approval of the Public Health and Health Planning Council (PHHPC).

Please submit all requests to: LHCSA-Amend@health.ny.gov.

Questions regarding this form should be forwarded to homecareliccert@health.ny.gov or via phone to (518) 408-8784.