Schedule 7A
Limited Change of Ownership Notice

Instructions: For use in transactions pursuant to Section 461-b (9) of the Social Services Law or 10 NYCRR § 1001.4(o)(2) (transfer of less than10% of an interest or voting rights to a new person or any transfer to a person already approved by the Department of Health for this operator/entity). Attach additional sheets if necessary. Submit to the Division of Adult Care Facility & Assisted Living Surveillance, Bureau of Licensure and Certification, NYSDOH, 875 Central Ave., Albany, NY 12206. If change of ownership involves the exit of a previously approved person, submit at least 90 days prior to the intended effective date.

1. Operator Information

OPERATING CERTIFICATE NUMBER | TYPE OF FACILITY | LEGAL ENTITY THAT WILL OPERATE THE FACILITY (PROPOSED OPERATOR)

STREET AND NUMBER

CITY | COUNTY | ZIP

2. Contact Information

Applicant must designate one person to whom all official correspondence from the Department regarding this application should be addressed.

NAME AND TITLE

STREET AND NUMBER

CITY | STATE | ZIP

E-MAIL ADDRESS | TELEPHONE | FAX

3. Will any previously approved persons be relinquishing all of his or her interest in the approved operator or will a new person be added to the operator? ☐ Yes ☐ No

If Yes, attaché the transfer agreement and enter the date of the proposed transaction (must be no less than 90 days after submission of this form): _____

☐ Attachment # _____

If No, the change is effective upon the submission of this form to the Department.

4.Transaction Narrative: (Attach extra sheets if needed.) Describe the proposed change of interest or voting rights and indicate how the interest(s) will be acquired. Include the cost (if any) and source of funds to acquire the interest(s).

5. Transaction Summary: Provide the following information for all **current and new** stockholders, members or partners:

NAME	DATE APPROVED AS OPERATOR BY THE NYS DOH	NUMBER OF SHARES/PERCENTAGE INTEREST **BEFORE** PROPOSED TRANSACTION	NUMBER OF SHARES/PERCENTAGE INTEREST **AFTER** PROPOSED TRANSACTION

Include an Attachment 1 – Personal Qualifying Information for **New** Partners, Members or Shareholders and an Attachment 2 – Disclosure of New Stockholder's, Member's or Partner's and Relatives' Interest in Health Care Facilities or Programs for each new partner, member or stockholder listed above.

Attachment # _____

6. Operator's Organizational Documents: Attach all applicable revised organizational documents for the operator:

- ☐ Partnership Agreement; Attachment # _____
- ☐ LLC Operating Agreement; Attachment # _____
- ☐ Stockholder Affidavit for each stockholder whose percentage interest has changed; Attachment # _____
- ☐ Copy of an Executed Certificate of Assumed Name (for partnerships only); Attachment # _____

7. Authorizing Signature

SIGNATURE _____ DATE _____

PRINT OR TYPE NAME _____

TITLE _____

Personal Qualifying Information for New Partners, Members or Shareholders (Attachment 1)

NAME AND TITLE | BUSINESS OR PROFESSION

STREET AND NUMBER | DATE AND LOCATION OF BIRTH

CITY | STATE | ZIP | TELEPHONE NUMBER

License Held

NAME OF PROFESSION | LICENSE NO. | NAME OF PROFESSION | LICENSE NO.

GRANTED BY (AGENCY) | CITY OR STATE OF | GRANTED BY (AGENCY) | CITY OR STATE OF

SPECIALTY | DATE LICENSE ISSUED (MM/DD/YY) | SPECIALTY | DATE LICENSE ISSUED (MM/DD/YY)

LICENSED FROM (MM/DD/YY) TO (MM/DD/YY) | LICENSED FROM (MM/DD/YY) TO (MM/DD/YY)

Formal Education

FROM (MM/YY) | TO (MM/YY) | NAME | LOCATION | DEGREE

FROM (MM/YY) | TO (MM/YY) | NAME | LOCATION | DEGREE

FROM (MM/YY) | TO (MM/YY) | NAME | LOCATION | DEGREE

FROM (MM/YY) | TO (MM/YY) | NAME | LOCATION | DEGREE

Employment History for the Past 10 Years

FROM (MM/YY) | TO (MM/YY) | FIRM NAME | FIRM ADDRESS | POSITION HELD

FROM (MM/YY) | TO (MM/YY) | FIRM NAME | FIRM ADDRESS | POSITION HELD

FROM (MM/YY) | TO (MM/YY) | FIRM NAME | FIRM ADDRESS | POSITION HELD

FROM (MM/YY) | TO (MM/YY) | FIRM NAME | FIRM ADDRESS | POSITION HELD

FROM (MM/YY) | TO (MM/YY) | FIRM NAME | FIRM ADDRESS | POSITION HELD

FROM (MM/YY) | TO (MM/YY) | FIRM NAME | FIRM ADDRESS | POSITION HELD

Record of Legal Actions

A. Except for minor traffic violations, were you ever convicted of any violation of the law?	☐ Yes	☐ No
B. Have you ever been involved in a hearing before an official?	☐ Yes	☐ No
C. Are there any criminal actions pending against you?	☐ Yes	☐ No
D. Have you ever pleaded no lo contendere (no contest) to a felony charge?	☐ Yes	☐ No
E. Have you ever been named as a defendant in any civil action, including but not limited to malpractice, fraud or breach of fiduciary responsibility, including but not limited to Medicare and Medicaid issues?	☐ Yes	☐ No
F. Have you ever been held liable or enjoined by final judgment as a result of a criminal or civil action involving fraud, embezzlement, fraudulent conversion, or misappropriation of property?	☐ Yes	☐ No
G. Are you/have you ever been subject to an injunctive restrictive/restraining order, or federal or state restrictive/restraining order, relating to business or health care related activity as a result of an action brought by a public agency or department?	☐ Yes	☐ No
H. Are there now or have there ever been any civil or administrative actions pending against you or any professional/business entity with which you are affiliated?	☐ Yes	☐ No
I. Have you ever been a defendant in a hearing before an official body in relation to the operation of a home or institution caring for people?	☐ Yes	☐ No
J. Have you ever been dismissed or discharged from any employment at any healthcare provider for reasons other than lack of work or funds?	☐ Yes	☐ No
K. Have you ever forfeited bail or bond posted to guarantee your appearance in court to answer to any criminal charge?	☐ Yes	☐ No
L. Have you ever been denied approval to care for unrelated dependent children or adults, or had any such approval withdrawn?	☐ Yes	☐ No
M. Have you ever changed your name or used an alias, including changing your maiden name to a married name?	☐ Yes	☐ No
N. During the last 10 years, have you been refused a professional, occupational or vocational license by any public or governmental licensing agency or regulatory authority, or has such a license held by you during such period been suspended, revoked or otherwise subjected to administrative action?	☐ Yes	☐ No
O. Have you ever been involved in an action or proceeding brought by any public or governmental licensing agency or regulatory authority for violation of any securities, insurance or health law or regulation?	☐ Yes	☐ No
P. Have you ever been an officer, director, trustee, member, manager, partner, management employee or stockholder of a company, including the applicant company, where you occupied any such position or served in any such capacity wherein the company:	☐ Yes	☐ No
1. became insolvent, declared or was forced to declare bankruptcy or was placed in receivership or conservatorship?	☐ Yes	☐ No
2. was enjoined from or ordered to cease and desist from violating any securities, insurance or health law or regulation?	☐ Yes	☐ No
3. was the subject of an investigation by either federal or state law enforcement agencies on issues related to Medicare or Medicaid fraud?	☐ Yes	☐ No
4. was required to enter into a Corporate Integrity Agreement as part of a settlement with the Office of Inspector General of the U.S. Department of Health and Human Services or the New York State Office of the Medicaid Inspector General?	☐ Yes	☐ No
5. suffered the suspension or revocation of its certificate of authority or license to do business in any state?	☐ Yes	☐ No
6. was denied a certificate of authority or license to do business in any state?	☐ Yes	☐ No
7. If you have a been the subject of an Agency Action by New York State Office of the Medicaid Inspector General please disclose the details in full.	☐ Yes	☐ No

If the answer to any of these questions is "Yes", provide dates and details below:

Certfication

The undersigned hereby certifies, under penalty of perjury, that the above stated information is true, correct and complete.

SIGNATURE | DATE

PRINT OR TYPE NAME

TITLE

NOTARY (NOTARY MUST AFFIX STAMP OR SEAL) | DATE

Disclosure of New Stockholder's, Member's or Partner's and Relatives' Interest in Health Care Facilities or Programs (Attachment 2)

DATE OF BIRTH (MM/DD/YY)

STOCKHOLDER, MEMBER OR PARTNER NAME

DATE OF BIRTH (MM/DD/YY)

Name of relative(s) and relationship to the applicant or enter "Self" if disclosing applicant's ownership:

NAME

RELATIONSHIP

FROM (MM/YY) TO (MM/YY)

NAME AND ADDRESS

TYPE

☐ Open ☐ Closed
☐ Proposed

OFFICE HELD/NATURE OF INTEREST

NAME AND ADDRESS OF LICENSING AGENCY

NAME

RELATIONSHIP

FROM (MM/YY) TO (MM/YY)

NAME AND ADDRESS

TYPE

CERTIFICATE NUMBER (IF ANY)

☐ Open ☐ Closed
☐ Proposed

OFFICE HELD/NATURE OF INTEREST

NAME AND ADDRESS OF LICENSING AGENCY

NAME

RELATIONSHIP

FROM (MM/YY) TO (MM/YY)

NAME AND ADDRESS

TYPE

CERTIFICATE NUMBER (IF ANY)

☐ Open ☐ Closed
☐ Proposed

OFFICE HELD/NATURE OF INTEREST

NAME AND ADDRESS OF LICENSING AGENCY

NAME

RELATIONSHIP

FROM (MM/YY) TO (MM/YY)

NAME AND ADDRESS

TYPE

CERTIFICATE NUMBER (IF ANY)

☐ Open ☐ Closed
☐ Proposed

OFFICE HELD/NATURE OF INTEREST

NAME AND ADDRESS OF LICENSING AGENCY

The undersigned hereby certifies, under penalty of perjury, that the above stated information is true, correct and complete.

SIGNATURE

DATE

PRINT OR TYPE NAME

TITLE

NOTARY (NOTARY MUST AFFIX STAMP OR SEAL)

DATE