STATE OF MISSOURI
DEPARTMENT OF SOCIAL SERVICES
MISSOURI MEDICAID AUDIT AND COMPLIANCE
HCBS OWNERSHIP & STRUCTURE CHANGE REQUEST

SECTION 1: PROVIDER INFORMATION – COMPLETE ALL APPLICABLE FIELDS IN A LEGIBLE MANNER. Please complete ONE form per provider EIN. THIS IS A REQUIRED SECTION.

LEGAL AGENCY NAME AS IT APPEARS WITH THE IRS:			DOING BUSINESS AS NAME (IF APPLICABLE):		
NPI:			SSBG (optional):		
☐ *CDS*	☐ In-Home	☐ Reassessments	☐ Adult Daycare	☐ RCF (Residential Care)	☐ ALF (Assisted Living)

EMAIL ADDRESS FOR CONFIRMATION OF CHANGES:

SECTION 2: OWNERSHIP AND STRUCTURE – INCLUDING SALE/TRANSFER AND ORGANIZATIONAL STRUCTURE

Check the requirements below before submission; See 13 CRS 65-2.020 (11)

THE FOLLOWING MUST BE ATTACHED – USE THE CHECKBOXES TO CHECK OF DOCUMENTS:

1. ☐ Attach an original, signed letter on the agency's letterhead explaining in detail the type of change requested and the reason.
2. ☐ Attach a copy of the letter sent to participants notifying them of the change.
3. ☐ Copy of the Federal Tax ID number notification from the IRS that includes the agency name.
4. ☐ If adding a DBA, current Registration of Fictitious Business Name form filed with MO Secretary of State. DBA needs to be listed as owned 100% by legal entity, NOT the individual owner's name.
5. ☐ If canceling or dropping DBA, current Cancellation of Fictitious Name form filed with MO Secretary of State.
6. ☐ Copy of the ADC, RCF, or ALF license under the new name (if applicable).
7. ☐ Vendor Profile Form – Use the correct form for your provider type.
8. ☐ Business Organizational Structure form and all documents indicated under the Section completed on the form. List all managing employees and owners with full name, SSN and date of birth.
9. ☐ Current FSCR Screenings for any managing employee or owner listed on the BOS.
10. ☐ DSS-MMAC EFT Form and copy of either voided check or bank letter that has preprinted business name, account and routing.
11. ☐ For in-home services providers, Certificate of Insurance and Employee Dishonesty Bond issued in the new name.
12. ☐ Documentation showing updated NPI with updated information consistent with changes requested, i.e. legal name, authorized official, address. (https://nppes.cms.hhs.gov/#/)
13. ☐ Notification from the Missouri Department of Revenue of the business entity's Missouri Employer Identification Number.
14. ☐ Copy of signed bill of sale, purchase agreement, or merger documents including the date and the nature of the legal transaction.

☐ ***SALE OR TRANSFER OF OWNERSHIP***

DATE OF SALE/TRANSFER (MM/DD/YYY):			
DATE SELLING PROVIDER WILL CEASE BUSINESS (MM/DD/YYYY):			
SELLER'S NAME:			
BUYER'S NAME:			
BUYER'S CONTACT PERSON:			
BUYER'S PHONE NUMBER:			
BUYER'S ADDRESS:			
ADDRESS	CITY	STATE	ZIP
LOCATION WHERE RECORDS WILL BE STORED FOR 5 YEARS AFTER THE PURCHASE DATE:			
ADDRESS	CITY	STATE	ZIP
RECORD KEEPER NAME:			
RECORD KEEPER PHONE:			

SECTION 2: CHANGES TO AGENCY NAME

Check the requirements below before submission; See 13 CRS 65-2.020 (11)

THE FOLLOWING MUST BE ATTACHED – USE THE CHECKBOXES TO CHECK OF DOCUMENTS:

1. ☐ Attach an original, signed letter on the agency's letterhead explaining in detail the type of change requested and the reason.
2. ☐ Attach a copy of the letter sent to participants notifying them of the change.
3. ☐ Copy of the Federal Tax ID number notification from the IRS that includes the agency name.
4. ☐ If adding a DBA, current Registration of Fictitious Business Name form filed with MO Secretary of State. DBA needs to be listed as owned 100% by legal entity, NOT the individual owner's name.
5. ☐ If canceling or dropping DBA, current Cancellation of Fictitious Name form filed with MO Secretary of State.
6. ☐ Copy of the ADC, RCF, or ALF license under the new name (if applicable).
7. ☐ Vendor Profile Form – Use the correct form for your provider type.
8. ☐ Business Organizational Structure form and all documents indicated under the Section completed on the form. List all managing employees and owners with full name, SSN and date of birth.
9. ☐ Current FSCR Screenings for any managing employee or owner listed on the BOS.
10. ☐ DSS-MMAC EFT Form and copy of either voided check or bank letter that has preprinted business name, account and routing.
11. ☐ For in-home services providers, Certificate of Insurance and Employee Dishonesty Bond issued in the new name.
12. ☐ Documentation showing updated NPI with updated information consistent with changes requested, i.e. legal name, authorized official, address. (https://nppes.cms.hhs.gov/#/)
13. ☐ Notification from the Missouri Department of Revenue of the business entity's Missouri Employer Identification Number.
14. ☐ Copy of signed bill of sale, purchase agreement, or merger documents including the date and the nature of the legal transaction.

☐	***CHANGING LEGAL BUSINESS NAME***	EFFECTIVE MM/DD/YYYY:
	AGENCY NAME CHANGING TO:	
	AGENCY NAME FROM:	
☐	***ADDING A FICTITIOUS (DBA) NAME – LIST HERE:***	EFFECTIVE MM/DD/YYYY:
☐	***REMOVING A FICTITIOUS (DBA) NAME - LIST HERE:***	EFFECTIVE MM/DD/YYYY:
☐	***CHANGING A FICTITIOUS (DBA) NAME***	EFFECTIVE MM/DD/YYYY:
	DBA NAME FROM:	
	DBA NAME TO:	

SECTION 3: CHANGES TO FEDERAL EIN OR NPI – OWNERSHIP REMAINING THE SAME

Check the requirements below before submission; See 13 CRS 65-2.020 (11)

THE FOLLOWING MUST BE ATTACHED – USE THE CHECKBOXES TO CHECK OF DOCUMENTS:

1) ☐ Attach an original, signed letter on the agency's letterhead explaining in detail the type of change requested, the effective date and the reason for the changes.

2) ☐ Copy of the Federal Tax ID number notification from the IRS that includes the new agency name

3) ☐ **DSS-MMAC EFT Form**

4) ☐ Copy of current NPPES letter if changing NPI

☐	***CHANGING EIN***		
	OLD EIN:	NEW EIN:	EFFECTIVE MM/DD/YYYY:
☐	***CHANGING NPI***		
	OLD NPI:	NEW NPI:	EFFECTIVE MM/DD/YYYY:

SECTION 4: NOTES/ADDITIONAL COMMENTS – ANYTHING NOT REFERENCED IN ANY SECTION ABOVE. **PLEASE BE DESCRIPTIVE.**

THE AUTHORIZED SIGNER OF THIS DOCUMENT VERIFIES THAT HE/SHE IS AN INDIVIDUAL OR THE REPRESENTATIVE OF THE PROVIDER/VENDOR AND IS THE DULY AUTHORIZED AGENT TO EXECUTE THIS CHANGE REQUEST DOCUMENT ON BEHALF OF THE PROVIDER/VENDOR UNDER AUTHORITY GRANTED BY SAID PROVIDER/VENDOR.

(Original Signature) **Electronic signature is not acceptable.**	**Date:**
TYPE OR PRINT NAME OF AUTHORIZED PERSON SIGNING:	**TYPE OR PRINT TITLE OF AUTHORIZED SIGNER:**

PLEASE FAX FORM & ALL DOCUMENTS TO 573-634-3105. YOUR REQUEST WILL BE PROCESSED IN ORDER OF DATE RECEIVED.

Please do not e-mail your request unless MMAC has stated otherwise.

All pages of this request MUST be submitted along with any of the required documentation as noted for each section.

MISSOURI MEDICAID AUDIT AND COMPLIANCE USE ONLY BELOW:

☐ APPROVED	☐ REJECTED

ENTERED IN/VERIFIED (as applicable) : ☐ HCSPS ☐ DEX ☐ MMIS ☐ ISIGHT ☐ LEX/NEX ☐ SITE VISIT APPROVED

COMMENTS:

MMAC STAFF ID/SIGNATURE:	***DATE:***