GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Department of Health Care Finance

Change of Ownership Form

The current owner of an enrolled provider entity must notify DHCF of any anticipated change of ownership no fewer than thirty (30) calendar days prior to the change in ownership by completing and submitting this form.

Provider Name: _____Current DC Medicaid ID:_____

Name of Prospective Owner: _____

I hereby attest to the following:

☐ A disclosure has been made to the prospective new owner that the sale/transfer of the enrolled provider entity includes all known and unknown outstanding Medicaid liabilities; and

☐ A plan has been established to ensure continuity of care for all Medicaid beneficiaries currently receiving services from the enrolled provider entity.

Please attach a copy of tentative the tentative Sales Agreement, pending file transaction document.

Signature:_____

Email the completed change of ownership form (inc. supporting documents) to following address: **dhcf.providerenrollment@dc.gov**

Upon receipt the prospective owner will be contacted by DHCF/DPPPS