Please complete all areas of the form accurately. Thank you.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Change of Ownership Form | **Seller Information** | | **Buyer Information** | |
| **Legal Parent Name** |  | |  | |
| **DBA** |  | |  | |
| **Location Address** |  | |  | |
| **Billing Address** |  | |  | |
| **Parent County** |  | |  | |
| **Tax-ID** |  | |  | |
| **NPI** |  | |  | |
| **Medicaid ID** |  | |  | |
| **Provider Type** |  | |  | |
| **Contact Name** |  | |  | |
| **Contact Email** |  | |  | |
| **Notes** |  | |  | |
| **Date of Acquisition** |  | |  | |
| Is there an agreement regarding reimbursement between the buyer and Seller?  If yes, please check yes below. If not, check no and include the last billing date for the seller and the start billing date for the buyer as a SCA will be needed to fill in the gap while the credentialing review is in process. | | | | |
|  | **Yes**: | | **Yes**: | |
| **No**: | Last Billing Date: | **No**: | Start Billing Date: |

In addition to the completed Change of Ownership form, we need an updated [HDO Credentialing application](https://www.molinahealthcare.com/-/media/Molina/PublicWebsite/PDF/Providers/wi/Medicaid/forms/NEW_380-HDOAttestation-FINAL-es.ashx), a completed Provider Service Detail form (residential or ancillary), and the following documents:

* Copies of current organizational or facility licenses/certifications/registrations
* Copy of current (not expired) professional liability insurance face sheet
* Current W9 form
* Copy of the final purchase agreement\*

Completed documents should be sent to [MHWIProviderNetworkManagement@MolinaHealthcare.com](mailto:MHWIProviderNetworkManagement@MolinaHealthcare.com).

*\*Final Purchase Agreements are required to participate in the DHS Direct Care Workforce funding. For more information on DCW, reference the* [*DHS website*](https://www.dhs.wisconsin.gov/medicaid/ltc-workforce-funding-faq.htm)*.*