**Schedule 2**

**Personal Qualifying and Disclosure Information**

**Contents:**

* **Instructions – for Schedules 2A, 2B and 2C.**
* **Schedule 2A – Personal Qualifying Information.**
* **Schedule 2B – Personal Financial Statement for Individuals Contributing Capital in Support of the Project.**
* **Schedule 2C – Not-for-Profit Directors Statement.**
* **Schedule 2D – Instructions and Forms for Requesting Compliance Statements for Out-of-State Health Care Facilities.**

**Note: A separate schedule *must be filled out by each person required to file* personal information. Signed originals should be scanned and saved in PDF format for upload into the electronic application submission. Applicants should retain the originals.**

**Schedule 2A - Personal Qualifying Information**

**Schedule 2B - Personal Financial Statement**

**Schedule 2C - Director’s Statement for Not-For-Profit Applicants**

**INTRODUCTION**

Schedule 2 is required for directors, proprietors, and certain members and shareholders when an establishment application is filed, including certain transfers of ownership or interest. Ensure that responses are entered to ALL questions and that where required, the forms are signed and notarized. Refer to the specific type of transactions below for further instructions.

All attachments uploaded with the Schedule should be **typed or electronically produced,** descriptively labeled, and include the *individual’s full name*, relevant section of the form, and date of completion.

**Sole Proprietors**

Sole Proprietors must submit applicable Schedules 2A and 2B.

**Limited Liability Companies**

Each member and manager (regardless of percentage of ownership) must submit applicable Schedules 2A and 2B. These schedules are also required for all members, stockholders, officers, and directors of any member or parent corporation~~s~~ of the limited liability company.

**Not-for-Profit Corporations**

Any member, officer or director who contributes capital in support of the project must submit applicable Schedules 2A and 2B. Directors who do not contribute capital in support of a project must submit applicable Schedules 2A and 2C. Applicable Schedules 2A and 2C are also required for the officers and directors of any member corporations above the Agency or Facility in the corporate structure.

**Business Corporations**

Each stockholder (regardless of percentage of stock owned), officer and director must submit applicable Schedules 2A and 2B. For CHHAs, only stockholders who own ten percent or more of the CHHA’s issued stock must submit applicable Schedules 2A and 2B. For CHHAs, applicable Schedules 2A and 2B are also required for each stockholder, officer and director of any parent corporations.

**General or Registered Limited Liability Partnerships**

All partners must submit applicable Schedules 2A and 2B.

**Transfer of Ownership Interest**

Incoming owners, stockholders, members or partners who will own ten percent or more of a partnership, business corporation or limited liability company must submit applicable Schedules 2A and 2B. Transfers of less than ten percent to a new partner or stockholder may only require prior notice. Refer to the Department of health Guidance regarding when a Transfer of Ownership Interest Notice may be submitted in place of this Schedule.

**Medical/Center Directors**

For establishment of new Article 28 health care facilities, if the directors, proprietors, members or shareholders have no or limited health care delivery experience, a schedule 2A for the proposed Medical/Center Director must be submitted.

**Active Member Corporations**

Schedule 2A, and 2B or 2C, as applicable, are required for the stockholders, officers, directors, members and managers of an active parent corporation. A member corporation is considered active if it possesses **any** of the following powers:

* Appointment or dismissal of management-level employees and medical staff, except the election or removal of corporate officers;
* Approval of operating and capital budgets;
* Adoption or approval of operating policies and procedures;
* Approval of certificate of need applications filed by or on behalf of the facility;
* Approval of debt necessary to finance the cost of compliance with operational or physical plant standards required by law;
* Approval of contracts for management or clinical services; or
* Approval of settlements of administrative proceedings or litigation to which the facility is a party, except approval of settlements of litigation that exceed insurance coverage or any applicable self-insurance fund.

**Passive Parent/Member Corporations**

For CHHAs, Schedules 2A, and 2B or 2C, as applicable, are required for the stockholders, officers, directors, members and managers of a passive parent or member corporation, which typically holds only the power to elect the governing body of subsidiary corporations. Disclosure is required of all member/parent corporations in the operator’s organizational structure.

**Schedule 2 Worksheet**

The worksheet on the following page is intended to assist you and reviewers in identifying the persons for whom Schedules 2A, 2B or 2C are required and submitted.

**Table 2 Personal Information Tracker**

**\*Refer to the Instructions pages 1 and 2 to determine who should submit Schedule 2 and then enter the names accordingly on the following worksheet or upload a spreadsheet with the corresponding columns. Attachment #****.**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Legal Operator -  List Stockholder(s), Board Officer(s), Director(s), Member(s), Partners, Managers of Legal Operator and passive or active parents as applicable | Title or Position That Requires this Individual to Submit Schedule 2 | Mark "X " if Required to Submit this Schedule | | | | **DOH OFFICE USE ONLY**  **CON # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | |
|  |  | 2A | 2B | 2C | 2D | License # | SE | OP | MA | MC | OT |
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\* Please note exception for CHHAs on prior pages.

**Schedule 2A – Personal Qualifying Information**

**Complete all sections. TYPE or PRINT LEGIBLY to reduce requests for additional information and review time. If the answer is none or not applicable, please indicate such. All attachments must be labeled with individual’s full name, relevant section indicator, and date of completion. PDFs should be bookmarked as appropriate.**

1. **Personal Identifying Information**

|  |  |
| --- | --- |
| Last Name: |  |
| First Name: |  |
| Middle Initial: |  |
| Street Address: |  |
| City: |  |
| State: |  |
| Zip code: |  |
| Telephone: |  |
| Date of Birth: |  |
| Aliases\* |  |

\*Includes nicknames, name changes, maiden name, AKAs, etc.

1. **Formal Education** Include highest level of education obtained. Fill out the form below or upload a spreadsheet/document in the same format. Attachment #:

| School Name/Institution | Address | Attended | | Degree | Date Received |
| --- | --- | --- | --- | --- | --- |
| From | To |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
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1. **Professional Licenses Held Check box if not applicable**

Include all licenses held and attach copies if available. If expired, please provide an explanation. Fill out the form below or upload a spreadsheet/document in the same format. Attachment #:

| Type of Professional License  (Include Specialty) | State Issued | License Number | Effective Date | Expiration Date |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
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1. **Employment History for the Past 10 Years**

Currently Employed

Retired  If retired, please specify date of retirement:

Other  Specify:

***Upload your employment history, as an attachment to your Schedule 2A. NO handwritten attachments will be accepted.*** Attachment #:

The employment history can be resume, curriculum vitae or other document as long as it includes all employment activity for the past ten years and any employment activity which demonstrates competency to own and/or operate a health care facility. The employment history, starting with your most recent employment, must include the following information for each position:

* Name and full address of Employer
* Type of Business/Nature of Industry
* Dates of Employment
* Position/Title
* Position Responsibilities, particularly how they contribute to healthcare operation competency
* Reason for Departure

1. **Offices Held or Ownership in Health Facilities**

Provide separate lists of any affiliations you or any relatives have had in the past 10 years, per the instructions below, as an owner, operator, voting officer, director or principal stockholder of any health care, adult care, behavioral or mental health facility, program or agency requiring licensure or certification in New York State and in similar facilities or programs outside of New York State.

1. **Have you had an ownership interest or held an office in any facility or agency within the past 10 years, as described above? Yes**  **No** 
   * **If Yes,** **upload a spreadsheet or document**, as part of your Schedule 2A, with all affiliations in the format indicated below. ***NO handwritten attachments will be accepted.***

Attachment #:

* + For affiliations within the past 10 years with any facility, program or agency located ***outside*** ***of New York State***, refer to instructions for submitting a **Schedule 2D**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Applicant Ownership/Affiliation Information** | | | | | | | | | |
| **Ownership From** | **Ownership To** | **Facility Name** | **Legal Operator Name** | **Facility Address** | **Type of Facility** | **Facility**  **OpCert # (NYS) or License # or CCN (non-NYS)** | **Facility PFI (NYS)** | **Name and Address of Licensing Agency** | **% Interest Owned / Office Held** |

1. **FOR RESIDENTIAL HEALTH CARE FACILITY APPLICATIONS ONLY: Have any relatives had ownership interests in any facility or agency within the past 10 years, as described above? Yes**  **No** 
   * **If Yes,** **upload a spreadsheet or document**, as part of your Schedule 2A, with all affiliations in the format indicated below. ***NO handwritten attachments will be accepted.***

Attachment #:

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Relatives Ownership/Affiliation Information** | | | | | | | | | | | |
| **Name of Relative** | **Relation-ship to Applicant** | **Ownership From** | **Ownership To** | **Facility Name** | **Legal Operator Name** | **Facility Address** | **Type of Facility** | **Facility**  **OpCert # (NYS) or License # or CCN (non-NYS)** | **Facility PFI (NYS)** | **Name and Address of Licensing Agency** | **% Interest Owned / Office Held** |

1. **Enforcement Actions**

***For non-NYS facilities/agencies only:*** During the period of your affiliation, were any of the facilities/agencies subject to an enforcement or administrative action taken by the State regulatory agency due to the facility’s violation of applicable laws and regulations?

(***Must check on box***) **Yes  No**

* **If Yes, upload as an attachment to your Schedule 2A**, a comprehensive summary of all relevant details related to the violation(s). Attachment #:

Include, as applicable:

* + date of the action(s),
  + survey/inspection exit date,
  + nature of the issue(s),
  + scope and severity,
  + monetary penalties assessed or settlement amounts,
  + corrective action(s) taken,
  + the contact information for the issuing agency, if available
  + whether all actions have been resolved
    - If not, an explanation.
  + In lieu of all or parts of a summary, attaching a copy of the enforcement/administrative action(s) is acceptable.

1. **Pending Ownership**
2. Are there any submitted NYS Certificate of Need (CON) applications pending approval, or have not been fully executed, that involve ownership? **Yes  No**

**If Yes**, provide the project number(s): CON:       CON:

1. Are there any applications submitted and pending approval for health care facilities in other States? **Yes  No**

**If Yes**, please provide the information below or in an attachment to the schedule

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Facility Name | Facility Street | Facility City | Facility State | Application/ CON # |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

1. **Affirmative Statement of Qualifications**

As an attachment or in the space provided below, provide an affirmative statement explaining your qualifications to operate the proposed facility/agency. You may include any relevant community and/or volunteer background and experience. ***Failure to complete this section may cause a delay in processing the application and lead to possible denial/disapproval of an application.***

|  |
| --- |
|  |

1. **Record of Legal Actions - ALL QUESTIONS MUST BE ANSWERED**

Respond to the questions below ***on behalf of yourself individually and all entities that you are or were affiliated with*** (*i.e.*, serve(d) as an officer, director, trustee, member, partner, management employee, shareholder) or in such other position where you directed or caused the direction of the actions, management or policies of the entity.

**If you answer yes to any question, you MUST provide an attached explanation**

|  |  |
| --- | --- |
| 1. Have you ever been convicted, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court? | **Yes  No** |
| 1. Have you ever been named in any civil or administrative action in any court in any jurisdiction? | **Yes  No** |
| 1. Is any criminal charge or civil or administrative action pending against you in any court in any jurisdiction? | **Yes  No** |
| 1. Are you currently under investigation by any licensing board, professional organization or governmental agency? | **Yes  No** |
| 1. Have you ever been denied a fidelity bond, had a claim made against the bond, or had such a bond canceled or revoked? | **Yes  No** |
| 1. Have you ever become insolvent, declared bankruptcy, or been placed in receivership or conservatorship? | **Yes  No** |
| 1. Have you ever been granted a Certificate of Relief from Disabilities? | **Yes  No** |
| **For the following questions, your responses are for**  ***any time during the last 10 years (7 years for CHHAs)*** | |
| 1. Has any licensing or disciplinary authority ever refused to issue you a license, or ever revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, or refused to renew a license or certificate held by you? | **Yes  No** |
| 1. Has any licensing or disciplinary authority ever fined, censured, reprimanded or otherwise disciplined you? | **Yes  No** |
| 1. Have you ever been subject to any civil or administrative actions involving Medicaid or Medicare? | **Yes  No** |
| 1. Have you ever been involved in an action or proceeding or subject to sanctions by any public or governmental licensing agency or regulatory authority for violation(s) of any securities, insurance, or health law or regulation? | **Yes  No** |
| 1. Have you ever been involved in a hearing or action or proceeding brought by any official body or licensing or disciplinary authority regarding the operation of a home or facility caring for people? | **Yes  No** |
| 1. Have you ever been subject to arbitration or alternative dispute resolution (ADR) used in place of litigation or entered into a Corporate Integrity Agreement to settle a dispute related to business practices? | **Yes  No** |

**For any “Yes” responses to the questions above, upload as an attachment to your Schedule 2A, a summary of all relevant details, including the date, location, type, persons involved, and status of the action(s). *NO handwritten summaries will be accepted.***

1. **Declaration**

I affirm under penalty of perjury under the laws of the State of New York, that I have carefully read the questions in this application and have accurately and truthfully answered them; and any submission of accompanying documents for such questions are valid and complete. I understand that any false or misleading information in, or in connection with, my application may be cause for delay and possible denial or recommendation of disapproval of my application.

|  |  |
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| SIGNATURE: | DATE |
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| PRINT OR TYPE NAME | |
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| NOTARY | DATE |
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**NOTE: The original of this document *must be signed and notarized prior* to submission. The document should then be scanned and saved in PDF format for upload into the electronic application submission. Applicants should retain the originals.**

**Schedule 2B - Personal Financial Statement**

To be filled out by sole proprietors, general partners, LLC members and managers, shareholders, officers and directors of business corporations and directors of not-for-profit corporations who contribute capital. Directors of not-for-profit corporations who do not contribute capital should complete Schedule 2C instead. All net worth statements must be based on the most current information available. No statements can be over six months old unless accompanied by a current no material change affidavit. **All attachments must be labeled with individual’s full name, relevant section indicator, and date of completion.**

**N.B.** Exceptions for CHHAs are in schedule 2A.

1. **Personal Identifying Information**

|  |  |  |
| --- | --- | --- |
| Full name of the Individual |  | |
| Business or Profession |  | |
|  | | |
| Name of Employer |  | |
|  | | |
| List of other business ventures in which you are a partner or an officer |  | |
| Describe your business ventures |  | |
|  | | |
| Salary | |  |
| Fees or Commissions | |  |
| Other (Specify): | |  |
|  | | |
| Describe any contingent liabilities |  | |

**Balance Sheet: Summarizes from following sections**

Complete the below table or upload a spreadsheet as an attachment to the schedule.

Attachment #

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| ASSETS | | |  | LIABILITIES | |  |
| Cash (Section II) | | |  | Notes Payable (Section VII) | |  |
| Stocks and Bonds (Section III) | | |  | A. Banks | |  |
| Accounts Receivable | | |  | B. Relatives | |  |
| Notes Receivable | | |  | C. Health Care Facility | |  |
| A. Due from Relatives and Friends | | |  | D. Other (Specify) | |  |
| B. Due from others - Good | | |  | Accounts Payable | |  |
| C. Due from others - Doubtful | | |  | A. Health Care Facilities | |  |
| Real Estate Owned (Section V) | | |  | B. Other (Specify) | |  |
| Cash Surrender Value of Life Insurance | | |  | Mortgages Payable | |  |
| Health Facility Realty Interests | | |  | A. Health Care Facilities | |  |
| 1 |  | |  | B. Other (Specify) | |  |
| 2 |  | |  |
| 3 |  | |  |
| 4 |  | |  |
| 5 |  | |  |  | |
| 6 |  | |  |
| TOTAL | | |  |
| Business Interests (Itemize) (Section VIII): | | |  |
| 1 | |  |  | Federal and State Income Taxes Payable | |  |
| 2 | |  |  | Other Accrued Taxes & Interests Payable | |  |
| 3 | |  |  | Installment Contracts Payable | |  |
| 4 | |  |  | Other Liabilities (Itemize) | |  |
| 5 | |  |  | 1 |  |  |
| 6 | |  |  | 2 |  |  |
| 7 | |  |  | 3 |  |  |
| TOTAL | | |  | TOTAL | |  |
| AMOUNT OF ASSETS PLEDGED | | |  | AMOUNT OF LIABILITIES SECURED | |  |

|  |  |
| --- | --- |
| NET WORTH |  |

1. **Cash on Hand**

Complete the below table or upload a spreadsheet or table as an attachment to the schedule.

Attachment #

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| --- | --- | --- | --- |
| Name of Bank | Account # | Account Balance | Amt. Pledged (if any) |
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|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
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|  |  |  |  |
| Cash on Hand | |  |  |
| Total as Per Statement | |  |  |

1. **Stocks and Bonds**

Complete the below table or upload a spreadsheet or table as an attachment to the schedule.

Attachment #

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Stock ="S",  Bond = "B" | Name of Security (example "US Gov't. Series --") | In Name of | If Pledged, State to Whom | Present Market Value |
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1. **Real Estate Owned**

Complete the below table or upload a spreadsheet or table as an attachment to the schedule.

Attachment #

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| --- | --- | --- | --- | --- | --- | --- | --- |
| Location,  Type of Property | Date Acquired | Title in Name of | Cost | Recent Appraised Value | Method of Payment | Mortgage amount | |
| Original | Current |
|  |  |  |  |  |  |  |  |
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1. **Real Estate Mortgages Owned**

Complete the below table or upload a spreadsheet or table as an attachment to the schedule.

Attachment #

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Type of Lien (1st, 2nd, 3rd, etc.),  Location and Type of Property | Mortgages of Record | Original Amount | Method of Payment | Present Amount |
|  |  |  |  |  |
|  |  |  |  |  |
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Are there any principal payments, interest or taxes in arrears? Yes  No

Are there any unrecorded assignments:Yes  No

**If Yes** to either question, please explain below or upload an attachment. Attachment #

|  |
| --- |
|  |

1. **Life Insurance**

Complete the below table or upload a spreadsheet as an attachment to the schedule.

Attachment #

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Face Amount | Name of Company | Beneficiary | Loans Against Policy | Type of Policy | Cash Value |
|  |  |  |  |  |  |
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Are any of the above policies assigned except for loans as above? Yes  No

**If Yes**, please explain below or upload an attachment. Attachment #

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1. **Notes Payable**

Complete the below table or upload a spreadsheet as an attachment to the schedule.

Attachment #

|  |  |  |  |
| --- | --- | --- | --- |
| Payable to Whom? | Indicate Method of Borrowing and How Note  is Endorsed, Guaranteed, or Secured | Interest Rate | Current Balance Due |
|  |  |  |  |
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1. **Business Interests**

Are any of the assets business interests? Yes  No

**If Yes**, upload the latest available certified financial statements and/or federal income tax returns for the appropriate entity/ies.

|  |  |  |
| --- | --- | --- |
|  | **Attached** | **Attachment Title(s)** |
| Business interest latest Certified Financial Statement(s) and/or Federal Income Tax Return |  |  |
| **FOR RESIDENTIAL HEALTH CARE FACILITY APPLICATIONS ONLY:** The applicant must provide the certified financial statements for the last three years and the most current internal financial statements for the *subject Nursing Home and all affiliated NY Nursing Homes*.  **This information should be uploaded as an attachment to Schedule 9.** |  |  |

1. **Declaration**

I affirm under penalty of perjury under the laws of the State of New York, that I have carefully read the questions in this application and have accurately and truthfully answered them; and any submission of accompanying documents for such questions are valid and complete. I understand that any false or misleading information in, or in connection with, my application may be cause for delay and possible denial or recommendation of disapproval of my application.

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| --- | --- |
| SIGNATURE: | DATE |
| X |  |
| PRINT OR TYPE NAME | |
|  | |
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|  |  |
| NOTARY | DATE |
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**NOTE: The original of this document *must be signed and notarized prior* to submission. The document should then be scanned and saved in PDF format for upload into the electronic application submission. Applicants should retain the originals.**

**Schedule 2C - Director’s Statement for Not-for-Profit Applicants**

Full Name of Individual:

|  |
| --- |
|  |

This statement must be completed by directors of not-for-profit corporations who are not contributing capital in support of the project. The form is completed in lieu of Schedule 2B. This schedule is required for all not-for-profit establishment applications.

**Statement of Business Associations with Health Facilities**

I do NOT receive any income directly or indirectly from any other health care facility.

I do receive income directly or indirectly from the following health care facilities. For each, please briefly describe the nature of the relationship and method of payment.

|  |
| --- |
|  |

**Declaration**

I affirm under penalty of perjury under the laws of the State of New York, that I have carefully read the questions in this application and have accurately and truthfully answered them; and any submission of accompanying documents for such questions are valid and complete. I understand that any false or misleading information in, or in connection with, my application may be cause for delay and possible denial or recommendation of disapproval of my application.

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| NOTARY | DATE |
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**NOTE: The original of this document *must be signed and notarized prior* to submission. The document should then be scanned and saved in PDF format for upload into the electronic application submission. Applicants should retain the originals.**

###### Schedule 2D – Review of Out-of-State Facilities

**General Information**

**Completed 2D forms must be included at the time of the initial submission of the Certificate of Need application via NYSE-CON.** A Schedule 2D must be submitted for each affiliated out-of-state health care entity. The original schedule 2D should be completed by the state agency with jurisdiction. Due to the time involved in obtaining completed Schedule 2Ds from other states, sending the forms in a timely manner is suggested. If you have any questions related to the Schedule 2D forms or process, please contact the appropriate NYSDOH program bureau. A listing of program bureaus can be found on Attachment 2D-B.

Note that the term “health care entity” includes hospitals, nursing homes/residential health care facilities, home care agencies, hospices, diagnostic and treatment centers, ambulatory surgery centers, midwifery birth centers, adult day health care programs, laboratories, health maintenance organizations, pharmacies, substance use disorder programs, facilities for the mentally ill, facilities for the mentally retarded and developmentally disabled, adult care facilities, enriched housing programs, assisted living programs, and rehabilitation facilities. Please include only those agencies, facilities and programs that are licensed or certified in their respective states.

**Instructions**

1. Complete the **Schedule 2D Worksheet,** listing **every** affiliated out-of-state health care entity.
2. For **each affiliated health care entity** located in a state other than New York State, complete the applicant’s portion of the two-page New York State Department of Health Compliance Report Form.
   1. In the first paragraph, enter the applicant’s name and the date on which the completed form should be returned to you. If the out-of-state review is being conducted for a board member’s affiliations, ensure the Compliance Report Form reflects the name of the applicant and not the name of the board member. Allow thirty days for a response.
   2. In the next four gray-shaded fields, provide all identifying information for the entity to be reviewed, including its name, address, license or certificate number and the time period for which the review should be conducted. New York State requires a ten-year compliance history. If the entity has been operational or affiliated for less than ten years, enter the entire time period with which it was affiliated with the applicant or board member.
3. Forward the form(s) to the appropriate regulatory agency in each state. Enclose a stamped, addressed envelope and/or supply an email address to facilitate the state’s reply. A sample cover letter is provided in Attachment 2D-A.

**N.B**. Some states charge a fee for this information. The applicant is responsible for the payment of such fees.

**N.B**. For any health care entities purchased after the initial submission of the application, it is the applicant’s responsibility to obtain compliance reports and submit them to the Department.

1. If you are unable to obtain the completed schedule 2D from the state agency within a reasonable amount of time, contact the appropriate program bureau (based on the CON applicant facility type) listed on Attachment 2D-B. **Do not submit your application until you have discussed alternatives with the program bureau**.

**Schedule 2D Out-of-State Facilities Worksheet**

Attach one document/spreadsheet listing all affiliated out-of-state health care entities, in the format indicated below. *Every health care entity listed here should also be reflected on the list of affiliated entities submitted as part of Schedule 2A*

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Affiliation From** | **Affiliation To** | **Facility Name** | **Legal Operator Name** | **Facility Street and City Address** | **Facility State** | **Type of Facility** | **Facility License # or CCN** | **Name and Address of Licensing Agency** | **2D**  **Included**  **Indicator** |

**Compliance Report Form for Project #**

(For NYSDOH Use)

(Applicant) is submitting an application for ownership to the New York State Department of Health. In conjunction with the application, the Department requests compliance information regarding the health care facility/agency named below, which has been operated by or affiliated with the applicant for the specified time period. Please respond to the questions and provide details of any enforcement or administrative actions taken against the operator of this facility. Please also consider the operator’s complaint history. It is requested that this form be completed and returned by (Due Date).

**TO BE COMPLETED BY APPLICANT:**

|  |  |
| --- | --- |
| Name of Facility to be Reviewed: |  |
| Address of Facility: |  |
| State: |  |
| License or Certificate Number: |  |
| Time Period to be Reviewed: |  |

**TO BE COMPLETED BY STATE REGULATORY AGENCY:**

1. Time period reviewed, if different from requested time period:

1. Is the facility currently operational?  Yes  No

If yes, is the facility currently in compliance with all applicable codes, rules and regulations?  Yes No

If the facility is not currently in compliance, describe below the nature of the non-compliance.

1. Were any enforcement or administrative actions taken against the facility during the specified time period?  Yes  No

If yes, specify the number of actions.

If no, skip to Question 5.

1. Provide further details regarding **each** enforcement or administrative action taken.
2. Cite the violations specific to each enforcement or administrative action and indicate if state or federal, as applicable. Include dates of surveys relative to each.

1. Were any of these actions for repetitive violations?  Yes  No

If yes, please explain below.

1. Has the enforcement or administrative action(s) been resolved?

Yes  No

1. If yes, indicate the date the action(s) was resolved and specify any civil fine paid or corrective measures taken to resolve the action.

1. If no, indicate the current status of the enforcement or administrative action and if possible, indicate when it is expected to be resolved.

1. Are there any other issues regarding this facility which you feel the New York State Department of Health should be aware of in determining the character and competence of the applicant?  Yes  No

If yes, please explain.

|  |
| --- |
| Please provide a Contact Person for NYSDOH in case of follow-up questions |
| Name of Contact: |
| Title of Contact Person: |
| Phone (w/ Area Code): |
| E-Mail Address: |
| Date: |

**SAMPLE LETTER FOR OUT-OF-STATE REVIEW**

Dear (State Regulatory Agency):

An application for establishment/change in ownership is being prepared by (Applicant) to be submitted to the New York State Department of Health. As part of the regulatory requirements for establishing the character and competence of (Applicant), the Department must receive documentation that affiliated health care facilities/agencies/programs located in your state have been in substantial compliance with all applicable codes, rules and regulations.

The health care entity for which this information is requested is shown on the enclosed form. Please complete the form by responding to the questions and providing any additional information, as applicable. If documentation is not available for the entire time period requested, please indicate the dates for which you conducted your review. It is requested you complete and return the form by (Due Date). A stamped, addressed envelope is enclosed for your convenience.

Your assistance with this matter is appreciated. Should you have any questions regarding the form, please contact (DOH Reviewer/Unit) in the New York State Department of Health at (DOH Reviewer/Unit Phone/Unit Email).

Sincerely,

Enclosure

New York State Department of Health

Program Contact Information

**Nursing Home Applications** (518) 473-7285

Bureau of Nursing Home Licensure & Certification bnhls@health.ny.gov

875 Central Avenue

Albany, NY 12206

**Diagnostic & Treatment Center Applications** (518) 402-1003

Division of Hospitals and D&TCs dcscon@health.ny.gov

875 Central Avenue

Albany, NY 12206

**Home Care Applications** (518) 402-0926

Bureau of Home Care Licensure and Certification homecareapplications@health.ny.gov

875 Central Avenue

Albany, NY 12206

**Hospital Applications** (518) 402-1003

Division of Hospitals and D&TCs dcscon@health.ny.gov

875 Central Avenue

Albany, NY 12206

**Midwifery Birth Center Applications** (518) 402-1003

Division of Hospitals and D&TCs dcscon@health.ny.gov

875 Central Avenue

Albany, NY 12206

**Hospice Applications** (518) 402-0926

Bureau of Home Care Licensure and Certification homecareapplications@health.ny.gov

875 Central Avenue

Albany, NY 12206