LTSS Provider Change of Ownership Notification Form

(Please complete all areas accurately. Thank you.)

All documentation must be submitted in PDF format via email to MHWIProviderNetworkManagement@molinahealthcare.com.

Subject Line: "CHOW Submission – [Old Provider Name] to [New Provider Name]. Partial submissions will not be accepted.

(Example: OldCo Supportive Home Care to NewCo Supportive Home Care)

Field	Seller Info	Buyer Info
Legal Parent Name		
DBA (N/A if not applicable)		
Location Address		
Billing Address		
Parent County		
Tax ID		
NPI		
Medicaid ID		
Provider Type		
Service Type / Program *(check all that apply)*	☐ Supportive Home Care (SHC) ☐ Daily Living Skills (ADL) ☐ Respite Care ☐ Residential (AFH / CBRF) ☐ Supported Employment ☐ Other: _____	
Direct Care Workforce Eligible?	☐ Yes ☐ No	☐ Yes ☐ No
If DCW-eligible, will DCW positions and staff be retained post-transfer?	☐ Yes ☐ No ☐ N/A	☐ Yes ☐ No ☐ N/A
Does this CHOW Involve a TIN change?	☐ Yes ☐ No	
Contact Name		
Contact Email		
Secondary Contact (if applicable)		
Phone Number		
Notes		
Ownership Change Effective Date		
Date of Notification to Molina		

Reimbursement Agreement Between Seller and Buyer

Is there a reimbursement agreement in place? ☐ Yes ☐ No

If **No**, please complete the following:

- **Seller Last Billing Date**: _____
- **Buyer Start Billing Date**: _____
  - ☐ Seller agrees to final billing date
  - ☐ Buyer agrees to start billing under SCA
  - ☐ SCA Request Submitted (Date): _____

*(**Note:** A Single Case Agreement (SCA) may only be executed if the Buyer is actively enrolled with Wisconsin Medicaid **and** services were rendered prior to contract execution. The SCA must be fully executed before the Buyer may submit claims for payment. If the provider is DCW-eligible, the billing transition must also align with DHS CHOW approval timelines. Beginning **March 31, 2026**, SCAs may not be executed for non-enrolled providers under any circumstances.)*

Reason for Ownership Change (optional)

☐ Merger

☐ Acquisition

☐ Internal Restructuring

☐ Other (please describe): _____

Required Supporting Documents

Please submit the following documents in **PDF format**:

☐ Updated HDO Credentialing Application

☐ Completed Provider Service Detail Form (Residential or Ancillary – provided by Contracting)

☐ Copies of current organizational/facility licenses, certifications, or registrations

☐ Copy of current (not expired) professional liability insurance face sheet

☐ Current W-9 for **both** buyer and seller

☐ Signed and executed final Purchase Agreement, Bill of Sale, or equivalent legal documentation*

☐ ForwardHealth Medicaid Enrollment Approval Letter or Confirmation Email (Required for all providers; mandatory for contract execution or SCA if services were rendered prior to contracting)

☐ Proof of Business Registration / EIN Verification (if TIN changed)

☐ DCW Staff Retention Plan or Statement (if DCW-eligible)

Submission Instructions

Submit all materials via email to: MHWIProviderNetworkManagement@MolinaHealthcare.com

Please include: **Subject Line: "CHOW Submission – [Old Provider Name] to [New Provider Name]"**

You will receive confirmation of receipt within **3–5 business days**.

If your organization is **DCW-eligible**, the Contracting Team will submit your CHOW packet to Wisconsin DHS following completion.

**Final Purchase documentation is only required for DHS submission if the provider is DCW-eligible under DHS guidance. For more information on DCW, visit the DHS website.*