



**STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH SERVICES PLANNING AND REVIEW BOARD**

**Form 301B INSTRUCTIONS
APPLICATION FOR TRANSFER OF OWNERSHIP OF HEALTH CARE
FACILITY**

All persons who are requesting a transfer of ownership of a health care facility under the requirements of New Hampshire RSA Section 151-C:5 II (b) must complete Form 301B. This form consists of two sections that should provide the Office of Health Services Planning and Review (HSPR) with sufficient information to determine if the proposal meets the requirements. The sections are:

Section I Identifying Information
Section II Affidavit

All portions of Sections I and II **must be completed**. If any portion is incomplete the application will be returned to you for completion.

HSPR requires an original and 15 copies of your completed Form 301B. All pages must be consecutively numbered. Please submit the completed Form 301B to:

Office of Health Services Planning and Review
29 Hazen Drive
Concord, NH 03301-6504

Forms must be submitted by the first Wednesday of the month in order to be considered for the monthly HSPR Board meeting agenda. Forms not received by the deadline will be considered for the next HSPR Board meeting agenda.

If you have any questions concerning this form, please contact Cynthia Carrier at (603) 271-4606.



**STATE OF NEW HAMPSHIRE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH SERVICES PLANNING AND REVIEW BOARD**

**FORM 301B
Transfer of Ownership of Health Care Facility**

All persons who are requesting a transfer of ownership of health care facility under the requirements of New Hampshire General Statutes, Sections 151-C:5 II (b) must complete this form. Please submit the completed form to:

Office of Health Services Planning and Review
29 Hazen Drive
Concord, NH 03301-6504

SECTION I. IDENTIFYING INFORMATION

Please complete Parts A, B, C and D.

A. Facility Information	
Facility Name:	
Facility Address:	
Number of Beds:	
Medicare/Medicaid Number:	
License Number:	

B. Owner Information

	Current Owner	Proposed Owner (Applicant)
Full Legal Name:		
Doing Business As:		
Name of Parent Corporation:		
Applicant's Mailing Address, if Post Office Box, include a street mailing address for Certified Mail:		
Contact Person, including Title/Position: This Individual will be the Applicant's Designee to receive all correspondence in this matter.		
Contact Person's mailing address, if PO Box, include a street mailing address for Certified Mail:		
Contact Person's Telephone Number:		
Contact Person's Fax Number:		
Contact Person's e-mail Address:		

C. Description

Please provide a brief description of the nature of the transaction:

--

D. Cost Information

Transaction Cost:	
-------------------	--

Associated Capital Costs:	
---------------------------	--

Other Costs: (Specify)	
---------------------------	--

SECTION II. AFFIDAVIT

To be completed by the Applicant:

I, _____, _____,
Name of the authorized representative Title

of _____, being duly sworn, depose and
Facility Name

attest that said facility is currently and will remain Medicare and/or Medicaid certified and complies with all of the criteria for said programs.

Signature Date

Subscribed and sworn to before me on _____

Notary Public/Commissioner of Superior Court

My commission expires: _____