**Request for Rate Adjustment and Attestation of Change of Ownership to an Unrelated Party**

**TO:** John Upchurch

Director of Reimbursement

Georgia Department of Community Health

**RE:** Rate Adjustment Request and Attestation of Change of Ownership to an Unrelated Party between January

1, 2012 and June 30, 2014

I, (*print name*), (*print title*) of

(*print name of nursing facility*), (*print Medicaid provider ID number of nursing facility*) (hereinafter referred to as the “nursing facility”) am authorized by virtue of my position to speak on behalf of the nursing facility.

I request a rate adjustment effective July 1, 2015 for the nursing facility named above.

I attest that the nursing facility had a full change of ownership during the period of January 1, 2012 through June 30, 2014 and, therefore, is eligible for a rate adjustment to reflect the facility’s cost under the new owner. The previous owner/owners of the nursing facility was/were \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (*print name*). The current owner/owners of the nursing facility is/are \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (*print name*). The change of ownership occurred on \_\_\_\_\_\_\_\_\_\_\_\_\_ (*print date*).

I further attest that the new owner/owners of the nursing facility is/are not a related party to the previous owner/owners. Related parties shall be defined to include the following:

1. Immediate family members including the previous owner’s spouse, child, sibling, parent, grandparent, or grandchild.  Related parties shall also include stepparents, stepchildren, stepsiblings, and adoptive relationships; and
2. A business corporation, general partnership, limited partnership, limited liability company, limited liability partnership, joint venture, nonprofit corporation, or any other for profit or not for profit entity that owns or controls, is owned or controlled by, or operates under common ownership or control of the previous owner.

*Knowingly filing a false or fraudulent attestation statement with the Department of Community Health is a violation of state law punishable with up to $1,000 in fines and five years in prison.*

Signature Date

Print Name Email Address

Print Title Telephone Number

Return Completed Forms to Mr. Darryl Threat by Fax or Email

Fax: (404)657-4199

Email: [dthreat@dch.ga.gov](mailto:dthreat@dch.ga.gov)