



USER MANUAL

CHOP Reference Guide

Change of Operator (CHOP)



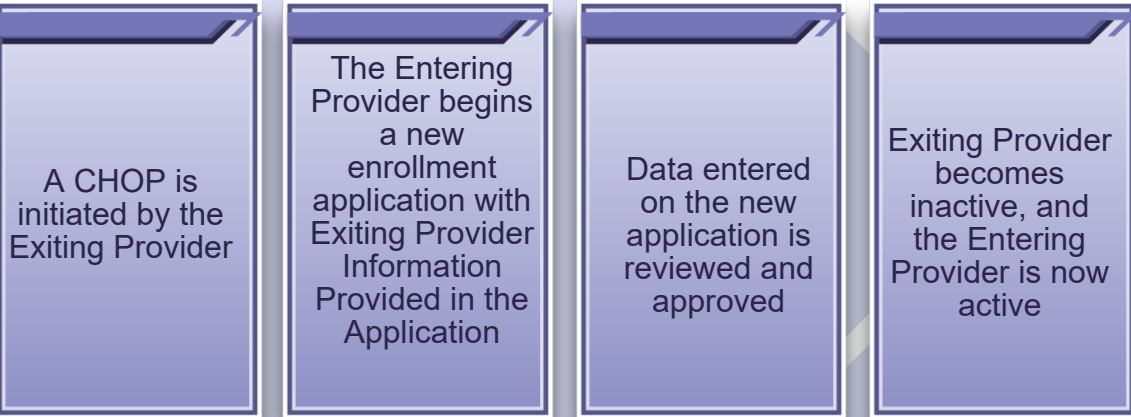
Department of
Medicaid

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Introduction

This document discusses the steps and functions of initiating a Change of Operator (CHOP) in PNM. In the overall process, files will be initiated by the Exiting Provider when a Change of Operator is requested. Once the Change of Operator (CHOP) is initiated by the Exiting Provider, the Entering Provider will complete a new enrollment application.



Initial Login to PNM

In this section of the user manual we will review the initial steps of logging into PNM. All users will log into the PNM system by using IOP (Innovate Ohio Platform).

Step 1: Visit the PNM web address: https://ohpnm.omes.maximus.com/OH_PNM_PRD/Account/Login.aspx

Step 2: Enter the User ID and click 'Next'

Step 3: Click 'Go to IOP'

The image displays two screenshots of the PNM login page. The first screenshot shows the 'Login' page with a text input field for 'Please enter your User ID' and a 'Next' button. A red circle with the number '2' is overlaid on the 'Next' button. Below the input field, there are links for 'Don't have an Account? Click here' and 'Forgot User ID?'. The second screenshot shows the same page, but the 'Next' button has been replaced by a 'Go to IOP' button, and a red circle with the number '3' is overlaid on it. The rest of the page content, including the 'Latest News' section and 'Why use OHJID?' information, remains the same in both screenshots.

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Step 4: The system will prompt you to enter your username and password on the IOP login screen illustrated below

The image shows two overlapping screenshots from a web application. The top screenshot is the OH|ID login page. It features the OH|ID logo at the top, followed by the text "Ohio's Digital Identity. One State. One Account." and "Register once, use across many State of Ohio websites". A prominent "Create Account" button is centered. Below this is a "Log In" section with two input fields: "OH|ID" (with a red circle containing the number 4 next to it) and "Password" (with a toggle icon). A "Log in" button is positioned below the fields. At the bottom of the login page are links for "Forgot OH|ID?" and "Forgot password?".

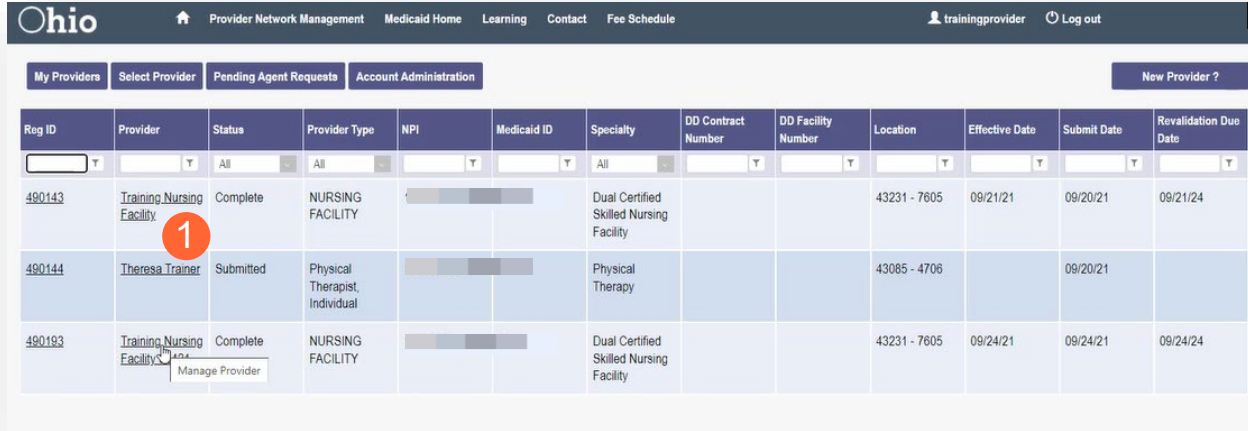
The bottom screenshot is a "Terms" dialog box. It has a blue header with the word "Terms". The main text reads: "Whoever knowingly, or intentionally accesses a computer or computer system without authorization or exceeds the access to which that person is authorized, and by means of such access, obtains, alters, damages, destroys, or discloses information, or prevents authorized use of the information operated by the State of Ohio, shall be subject to such penalties allowed by law. All activities on this system may be recorded and/or monitored. Individuals using this system expressly consent to such monitoring and evidence of possible misconduct or abuse may be provided to appropriate officials. Users who access this system consent to the provisions of confidentiality of the information being accessed, but have no expectation of privacy while using this system." Below this, it states: "In the event that an unauthorized user is able to access information to which they are not entitled, the user should immediately contact the site administrator." At the bottom left, there is a red circle with the number 5 next to a checkbox and the text "Yes, I have read the agreement". A "Cancel" button is located at the bottom right.

Step 5: The next screen will allow you to 'Accept the Terms' to log into the PNM system by clicking the terms box

Initiating a CHOP (Exiting Provider)

This section demonstrates the CHOP (Change of Operator) process when initiated by the Exiting Provider.

Step 1: From the list of providers on the Homepage/Dashboard, click on the link under Reg ID or Provider for the provider that will be the 'Exiting Provider' for the CHOP



The screenshot shows the Ohio Provider Network Management dashboard. The top navigation bar includes the Ohio logo, a home icon, and links for Provider Network Management, Medicaid Home, Learning, Contact, and Fee Schedule. The user is logged in as 'trainingprovider' and can click 'Log out'. Below the navigation bar are tabs for 'My Providers', 'Select Provider', 'Pending Agent Requests', and 'Account Administration', along with a 'New Provider?' button. The main content is a table with the following columns: Reg ID, Provider, Status, Provider Type, NPI, Medicaid ID, Specialty, DD Contract Number, DD Facility Number, Location, Effective Date, Submit Date, and Revalidation Due Date. The first row (Reg ID 490143) is highlighted, and a red circle with the number '1' is placed over the 'Reg ID' cell. The second row (Reg ID 490144) shows a provider named 'Theresa Trainer' with a status of 'Submitted'. The third row (Reg ID 490193) shows a provider named 'Training Nursing Facility' with a status of 'Complete' and a 'Manage Provider' link.

Reg ID	Provider	Status	Provider Type	NPI	Medicaid ID	Specialty	DD Contract Number	DD Facility Number	Location	Effective Date	Submit Date	Revalidation Due Date
490143	Training Nursing Facility	Complete	NURSING FACILITY			Dual Certified Skilled Nursing Facility			43231 - 7605	09/21/21	09/20/21	09/21/24
490144	Theresa Trainer	Submitted	Physical Therapist, Individual			Physical Therapy			43085 - 4706		09/20/21	
490193	Training Nursing Facility	Complete	NURSING FACILITY			Dual Certified Skilled Nursing Facility			43231 - 7605	09/24/21	09/24/21	09/24/24

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Step 2: On the Provider Management Home page, under the Manage Application section, click the '+' icon to expand the Enrollment Actions

The screenshot shows the 'Provider Management Home' interface. Under the 'Registration Information' section, there are five input fields: 'Provider Name' (Training Nursing Facility Two), 'Medicaid ID' (0000053), 'Effective Date' (08/15/2022), 'Revalidation Due Date' (08/15/2025), and 'Term Date'. Below this is the 'Manage Application' section, which includes three expandable items: 'Enrollment Actions' (marked with a red circle '2'), 'Programs', and 'Self Service'. Each item has a '+' icon and a corresponding selection box.

Step 3: Under the Enrollment Actions, click the hyperlink labeled 'Initiate CHOP'

The screenshot shows the 'Manage Application' page with the 'Enrollment Actions' dropdown expanded. The dropdown menu lists several options: 'Begin ODM Enrollment Profile Update', 'Add ODA Services', 'Edit Key Provider Identifiers', 'Request Disenrollment', 'Initiate CHOP' (marked with a red circle '3'), and 'Submit 90 Day Closure'. The 'Initiate CHOP' option is highlighted in blue.

Step 4: A pop-up appears requesting a 45-day notice. Click 'Choose File' to locate the document on your computer. Once located, select the document, and click 'Open.' When the file has been selected, click 'Upload.'

The screenshot shows the 'Initiate 45 Days Notice' dialog box. It has a 'Choose File' button and a text field that says 'No file chosen'. Below the text field are 'Upload' and 'Cancel' buttons. A red circle '4' is positioned to the left of the 'Upload' button.

The screenshot shows the 'Initiate 45 Days Notice' dialog box with a file selected. The 'Choose File' button is now disabled, and the text field contains 'Notice.pdf'. Below the text field are 'Upload' and 'Cancel' buttons. A red circle '4' is positioned to the left of the 'Upload' button.

Uploading the '45 Days Notice' begins the CHOP process. PNM will display a message stating that the CHOP has been initiated.

CHOP has been initiated.

Entering a New Provider (Entering Provider)

Now the Entering Provider needs to provide their records to continue the CHOP process. This section demonstrates the entering of the new Provider.

Step 1: From the Homepage/Dashboard, click 'New Provider?' to begin a new application.

Reg ID	Provider	Status	Provider Type	NPI	Medicaid ID	Specialty	DD Contract Number	DD Facility Number	Location	Effective Date	Submit Date	Revalidation Due Date
490143	Training Nursing Facility	Complete	NURSING FACILITY			Dual Certified Skilled Nursing Facility			43231 - 7605	09/21/21	09/20/21	09/21/24
490144	Theresa Trainer	Submitted	Physical Therapist, Individual			Physical Therapy			43085 - 4706		09/20/21	
490193	Training Nursing Facility_92421	Complete	NURSING FACILITY			Dual Certified Skilled Nursing Facility			43231 - 7605	09/24/21	09/24/21	09/24/24

Step 2: Under Application Type, click 'Select' for the Change of Operator option

"Please note that you have 10 days to complete your application. After 10 days, your information will be removed and you will have to re-start the process from the beginning of the application."

Standard application	Ordering, Referring, Prescribing	Change of Operator	MCP Single Case
Use this application if you are applying to become a new individual, group, facility, or institutional provider to provide fee-for-service for the State Medicaid program.	Use this application if you are applying solely for the purpose of Ordering, Referring or Prescribing.	Use this option if you want to initiate a Change of Operator for Skilled Nursing Facility or Intermediate Care Facility for individuals with intellectual disabilities.	Use this application if you are entering into a Single Case agreement with a Managed Care Plan.
Select	Select	Select	Select

[Click here for more application types...](#)

Step 3: Click 'Facility/Institution'

Application Type [Change](#)

3 Facility/Institution

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Step 4: On the Key Identifiers page, fill out the required fields and click 'Save'

Application Type: Change of Operator [Change](#)

Category*: Facility/Institution [Change](#)

Provider Type*: 86 - NURSING FACILITY

Name of Business Entity*: Training Nursing Facility New

Exiting Provider Medicaid ID: 0000053

Exiting Provider NPI: 1972517738

Exiting Provider Name: Training Nursing Facility Two

Business Name as it appears on your IRS Assignment letter

Tax ID Type*: EIN SSN

Tax ID*: 181164991

NPI*: 1811649916

Requested Effective Date*: 8/15/2022

Zip Code*: 43231

Zip Code Extension*: 7605

4 [Save](#) [Cancel](#)

Step 5: Select a Taxonomy from the drop-down menu and click 'Save' again.

Taxonomy is required.

Application Type: Change of Operator [Change](#)

Category*: Facility/Institution [Change](#)

Provider Type*: 86 - NURSING FACILITY

Name of Business Entity*: Training Nursing Facility New

Exiting Provider Medicaid ID: 0000053

Exiting Provider NPI: 1972517738

Exiting Provider Name: Training Nursing Facility Two

Business Name as it appears on your IRS Assignment letter

Tax ID Type*: EIN SSN

Tax ID*: 181164991

NPI*: 1811649916

Requested Effective Date*: 8/15/2022

Zip Code*: 43231

Zip Code Extension*: 7605

Taxonomy*: Nursing Facility/Intermediate Care Facility (313M00000X)

5 [Save](#) [Cancel](#)


CHANGE OF OPERATOR (PROVIDER)

Step 6: Fill all the necessary fields on the application and click 'Next' at the top of the page. Begin with completing the Provider Information section.

Provider Information
This is a required section.

Save Cancel **Next**

6



Name of Business Entity* Training Test Nursing Facility

DBA*

Practice Type*

Ownership Type*

Tax ID* 176085664

NPI 1760856645

NPI Start Date 11/16/2015

Provider Type* 86 - NURSING FACILITY

Revalidation Date Not Set Yet

Enrollment Status Not Set Yet


Enrollment Status Reason Not Set Yet

Step 7: Fill all the necessary fields for Primary Contact on the application and click 'Next' at the top of the page

Primary Contact Information
This is a required section.

Save Cancel Previous **Next**

7
History



Name* Tom Trainer

The primary contact is the main person responsible for the information submitted.

Title

Address 1* 2400 Corporate Exchange Drive

Address 2

City* Columbus

State* OH

County

Zip* 43231

Ext Zip

Phone Number 1* (614) 555-4321

Phone Ext 1

Yes No Indicate this is a cell phone if you wish to receive text message. Standard text messaging and data rates may apply.

Phone Number 2

Phone Ext 2

Yes No Indicate this is a cell phone if you wish to receive text message. Standard text messaging and data rates may apply.

Fax Number 1

Fax Number 2

Email Address 1* trainer@trainingfacility.com

Email Address 2

Office Manager

CHANGE OF OPERATOR (PROVIDER)

Step 8: If you want, enter Credentialing Contact information, and click 'Next.' If you want to skip this section, click 'Next' before entering information

Add Contact

No records found

8 Add New

History

*Contact Name

*Practice Name

*Contact Phone No

Contact Phone Extension

Contact Fax No

*Contact Email

Step 9: Enter the Primary Service Address details and click 'Next'

Note: The Primary Service location address information is the same as the information for the Exiting Provider and cannot be changed by the Provider. It is greyed out.

Primary Service Address
This is a required section.

Save Cancel Previous Next

9 History

Organization Name* Training Nursing Facility New

Primary Service Address* 2400 CORPORATE EXCHANGE DR

Address 2

City* COLUMBUS

State* OH

County

Zip* 43231

Ext Zip* 7605

Phone Number 1* (614) 555-4321

Phone Ext 1

Phone Number 2

Phone Ext 2

Fax Number 1

Fax Number 2

Contact Name

Email Address 1* ttrainer@newnursing.com

CHANGE OF OPERATOR (PROVIDER)

Step 10: Enter the Billing & Payment Address details and click 'Next.' If the address is the same as the Practice Location (Primary Service Address) you can check the box at the top of the page

Billing & Payment Address
This is a required section.

Save Cancel Previous Next

10
atory

Same as Practice Location

Address Type Individual Organization

Organization Name* Training Test Nursing Facility

Title

Address 1* 2400 CORPORATE EXCHANGE DR

Address 2

City* COLUMBUS

State* OH

County Franklin County

Zip* 43231

Ext Zip* 7605

Phone Number 1* (614) 555-4321

Phone Ext 1

Phone Number 2

Phone Ext 2

Fax Number 1

Fax Number 2

Contact Name

Email Address 1* trainer@trainingfacility.com

Step 11: Enter the Correspondence Address details and click 'Next.' If the address is the same as the Practice Location (Primary Service Address) you can check the box at the top of the page

Correspondence Address
This is a required section.

Save Cancel Previous Next

11
ory

Same as Practice Location

Address Type Individual Organization

Organization Name* Training Test Nursing Facility

Address 1* 2400 CORPORATE EXCHANGE DR

Address 2

City* COLUMBUS

State* OH

County Franklin County

Zip* 43231

Ext Zip* 7605

Phone Number 1* (614) 555-4321

Phone Ext 1

Phone Number 2

Phone Ext 2

Fax Number 1

Fax Number 2

Contact Name

Email Address 1* trainer@trainingfacility.com

CHANGE OF OPERATOR (PROVIDER)

Step 12: Enter the 1099 Address details and click 'Next.' If the address is the same as the Practice Location (Primary Service Address) you can check the box at the top of the page

1099 Address
This is a required section.

Save Cancel Previous Next

12
History

Same as Practice Location

Address Type Individual Organization

Organization Name* Training Test Nursing Facility

Address 1* 2400 CORPORATE EXCHANGE DR

Address 2

City* COLUMBUS

State* OH

County Franklin County

Zip* 43231

Ext Zip* 7605

Phone Number 1* (614) 555-4321

Phone Ext 1

Phone Number 2

Phone Ext 2

Fax Number 1

Email Address 1* trainer@trainingfacility.com

IRS Tax Type SSN FEIN

IRS Tax ID 176085664

Tax Exempt Yes No

W9 Form Yes No

Form 147 Yes No

CHANGE OF OPERATOR (PROVIDER)

Step 13: Enter the Home Office Address details and click 'Next.' If the address is the same as the Practice Location (Primary Service Address) you can check the box at the top of the page

Home Office Address
This is a required section.

Save Cancel Previous Next

13 history

Same as Practice Location

Address Type Individual Organization

Organization Name* Training Test Nursing Facility

Title

Address 1* 2400 CORPORATE EXCHANGE DR

Address 2

City* COLUMBUS

State* OH

County Franklin County

Zip* 43231

Ext Zip* 7605

Phone Number 1* (614) 555-4321

Phone Ext 1

Phone Number 2

Phone Ext 2

Fax Number 1

Fax Number 2

Contact Name

Email Address 1* trainer@trainingfacility.com

CHANGE OF OPERATOR (PROVIDER)

Step 14: Click the 'Add New' button to add the Long-Term Care Address(es). If the address is the same as the Practice Location (Primary Service Address) you can check the box at the top of the page. Make sure to select the location type from the drop-down menu.

Long Term Care Addresses
This is a required section.

Save Cancel Previous Next

14 History

No records found.

Add New

Same as Practice Location

Location Type* Facility Address

Address Type Individual Organization

Organization Name* Training Test Nursing Facility

Address 1* 2400 CORPORATE EXCHANGE DR

Address 2

City* COLUMBUS

State* OH

County

Zip* 43231

Ext Zip* 7605

Phone Number 1* (614) 555-4321

Phone Ext 1

Phone Number 2

Phone Ext 2

Fax Number 1

Fax Number 2

Contact Name

Email Address 1* trainer@trainingfacility.com

Step 15: Add new Specialties by clicking 'Add New' button, enter the details and then click 'Next' to continue

Specialties
This is a required section.

Save Cancel Previous Next

15 History

Add New

Primary Specialties are not editable by provider after application submission.

Specialty*

Start Date* 8/16/2022



End Date 12/31/2299

CHANGE OF OPERATOR (PROVIDER)

Step 16: Add additional taxonomies if relevant by clicking 'Add New' then enter the details and click on 'Next' to continue

Specialties
This is a required section.

Primary Specialties are not editable by provider after application submission.

Specialty	Primary	Start Date	End Date	Enroll Status	
870 Medicaid Only Nursing Facility	Yes	05/16/2022	12/31/2299	INACTIVE	 

[Add New](#)

[History](#)

Save Cancel Previous **Next**

16

Step 17: Add an out of state Medicare number and/or Medicaid number by clicking the corresponding 'Add New' button. Enter the details and then click 'Next' to continue

Note: If Medicare Enrollment Status is in process, then upload the Medicare Enrollment Certificate.

Medicare Number
This is not a required section. To skip this section click on Next button.

Medicare Number
No records found

[Add New](#)

Medicaid
No Other State Medicaid Number found

[Add New](#)

Save Cancel Previous **Next**

17

17

CHANGE OF OPERATOR (PROVIDER)

Step 18: Answer the question at the top of the page with either 'Yes' or 'No.'

If 'No' is answered, click 'Next' to proceed.

If 'Yes' is answered, indicate which MCP(s) you wish to indicate interest in contracting with. Click 'Next' to proceed

MCP Affiliation

This is not a required section. To skip this section click on Next button.

Save

Cancel

Previous

Next

Are you interested in contracting with any of the Ohio Medicaid Managed Care Plans?

18 Yes No

18

Indicate your interested in possible participation with one or more Ohio Medicaid Managed Care Plans

- AmeriHealth Caritas
- Anthem Blue Cross
- Aetna
- Buckeye
- CareSource
- Humana
- Molina
- United Health Care



Please Note: This indication does not ensure a contract with the Ohio Medicaid Managed Care Plans. Providers must still go thru the plan's contracting process, if applicable

Confirmed MCP Affiliations

Name	Start Date	End Date	Provider Type	Tracking Number	MITs Specialty
------	------------	----------	---------------	-----------------	----------------

No MCP affiliations found.

CHANGE OF OPERATOR (PROVIDER)

Step 19: Answer the question at the top of the page for Nursing Facility Ventilator with either 'Yes' or 'No.'

If 'No' is selected, click 'Next' to proceed.

If 'Yes' is selected, then additional questions must be answered, and this will add additional specialties to the entering provider's record. Click 'Save' to continue

Nursing Facility Ventilator
This is a required section.

Save Cancel Previous Next

19

Are you applying as a new nursing facility ventilator provider? No Yes

Ventilator Questions

Ventilators are connected to emergency outlets connected to a backup generator in an amount sufficient to meet the needs of ventilator dependent individuals.

No Yes

Respiratory care professional (RCP) is on-site at least 5 hours per week.

No Yes

Registered Nurse (RN) with 1-year experience working with ventilator dependent individuals is in the facility at least 5 hours per week.

No Yes

If ordered by a physician, initial therapy assessments can be done within 48 hours of receipt of order.

No Yes

If ordered by a physician, therapy is available for up to 2 hours per day, 6 days per week for each ventilator dependent individual.

No Yes

Stat laboratory services are available 24 hours per day, 7 days per week with results within 4 hours.

No Yes

For new admissions, pain medications can be administered within two hours from receipt of physician order.

No Yes

Has not been a special focus facility in past 6 months.

No Yes

Weaning Questions

A weaning protocol is in place established by a physician trained in pulmonary medicine who is available by phone 24 hours per day 7 days per week while weaning services are provided.

No Yes

A respiratory care professional (RCP) with training in basic life support is on-site 8 hours per day 7 days per week and available by phone during the remaining hours of the day while weaning services are provided.

No Yes

A Registered Nurse (RN) with training in basic life support is on-site 24 hours per day 7 days per week while weaning services are provided.

No Yes

Step 20: A message pop-up appears. Click 'OK' to approve additional specialties

Message

Your facility is approved for the Nursing Facility Chronic Ventilator Program effective 9/24/2021 1:09:04 PM

Your facility is approved for the Nursing Facility Weaning Program effective 9/24/2021 1:09:04 PM

20 OK

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Step 21: Complete the W9 form page by selecting the appropriate category, indicating the form you are uploading, and upload the form under the Required Document heading. Click 'Next' to proceed

W9 Form
This is a required section.

Information from the Identification page displayed below.
Corrections to this information must be made in Organization/Individual Identification and Primary Contact sections of the Identification page.

Legal Business Name:

EIN:

Select the most appropriate category below:

- Individual/sole proprietor of single-member LLC
- C Corporation
- S Corporation
- Partnership
- Trust/Estate
- Limited Liability C Corporation
- Limited Liability S Corporation
- Limited Liability Partnership
- Other

Indicate the form you are uploading

- W9
- Form 147

** Please visit <https://www.irs.gov/forms-pubs/about-form-w-9> to obtain a copy of the W9 with instructions.

Required Document

W-9

21 **W9_54.pdf** [Download](#) [Remove](#)

CHANGE OF OPERATOR (PROVIDER)

Step 22: On the EFT Banking Information page, answer the question at the top of the page with either 'Yes' or 'No.'

If 'No' is answered, click 'Next' to proceed

If 'Yes' is answered, information needs to be added under the Banking Information and EFT Contact sections. To provider this information, click 'Add New' under each section.

When all information has been entered, click 'Next' to proceed

EFT Banking Information

This is not a required section. To skip this section click on Next button.

Save Cancel Previous Next

22 Do you expect to receive payments directly from the State Medicaid Program (For example: Fee-for-Service Claims, Medicare Crossover Claims, Supplemental Pool Payments, Electronic Health Records Payments, etc.) as opposed to only payments from the Managed Care Contractors?
 Yes No

Instructions

READ INSTRUCTIONS BEFORE COMPLETING

- Electronic Fund Transfer (EFT) enrollment is required for a provider to enroll with the State Medicaid Program.
- Medicaid providers must submit this form to receive payment via EFT (Electronic Fund Transfer). It is also the responsibility of the Medicaid provider to ensure this information is updated, as necessary.
- The State Medicaid Program transmits the EFT via the NACHA standard CCD + format.
- It is the responsibility of the Provider to contact their financial institution to request the receipt of all data contained within the ACH information field (including the RTN Reassociation Trace Number) of the CCD + Addenda Record. This Trace Number uniquely identifies the transaction set and aids in reassociating payments and remittance advices.

Check here if the bank is outside of the United States. Per 1902(a)(80) of the Social Security Act, the State shall not provide any payment to any financial institution or entity located outside the United States.

Please enter your banking information below.

Banking Information

No banking information found. **22** Add New

EFT Contact

No EFT contact found. **22** Add New

Confirm

By selecting the confirmation box below, the submitting individual is attesting and acknowledging on behalf of the Medicaid Provider listed above that:

- He or she is authorized to complete and submit this Enrollment Form.
- The information provided is accurate and true.

I confirm the information provided is true and accurate.

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Step 23: On the Application Fee page, select to pay the fee via credit card or request a waiver of the application fee by selecting the appropriate button.

If paying by credit card, click 'Select Payment' and enter your credit card information.

If requesting a fee waiver, select the waiver reason from the drop-down menu, enter comments, and upload ad proof of payment document

When all details are entered, click 'Next'

Application Fee
This is a required section

Application Fee
All prospective, re-enrolling, and reactivating institutional providers are required to pay an application fee. You may request a waiver of the fee if you are already enrolled in Medicare and have already paid the application fee to Medicare. You may also request a waiver of the fee if you have paid the fee to another State Medicaid program. The current amount of the fee is \$595.00

You may also request a waiver of the fee if you have paid within the past 5 years.

Fee Amount \$595.00
Fee Status Pending

Payment Type Credit Card
23 Request Waiver of Application Fee

Authorize Payment **Select Payment**

Please note your Registration ID on the check.
Amount* \$595.00
Waiver Reason [Dropdown]
Comments [Text Area]

Fee Payment History

Fee Amount	Fee Status	Status Date	Waiver Reason	Transaction ID
No payment information found.				

Step 24: Enter the Owner Information. Scroll down and expand the 'Owner, Managing Employee and Controlling Interest Information' by clicking the '+' icon

the Provider Person or Provider Entity has direct or indirect ownership or control interest of 5 percent or more.
b. List whether any of the persons named in II(a) is related to another as a spouse, parent, child or sibling; and
c. List the name, address and TIN of any other Provider Entity in which a Person with an Ownership or Control Interest in the Provider Entity also has an Ownership or Control Interest. 42 C.F.R. §455.104

ITEM III
a. A Provider Entity must list the name, address, DOB, SSN and TIN for any Subcontractor with whom the Provider Entity has had singular business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request; and
b. A Provider Entity must list any significant business transactions between the Provider Entity and any Subcontractor or Wholly Owned Supplier during the 5-year period ending on the date of the request. 42 C.F.R. §455.105

ITEM IV (if you are a sole Provider you will fill out both parts of this item —
a) is about your employees
b) is about yourself
a. If you are filling out this form for Purpose 1 (i.e. on behalf of the Provider Entity) please list the following:
1. List the name, home address, DOB and SSN of each Person with an Ownership or Control Interest in the Provider Entity or is an Agent or Managing Employee of the Provider Entity;
2. Please list the name, home address, DOB and SSN of each Person with an Ownership or Control Interest in the Provider Entity that has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the title XX services program since the inception of those programs. 42 C.F.R. §455.106 Provider Entities shall search the List of Excluded Individuals/Entities (LEIE) each month for the names of the Providers Entities' employees and contractors.
b. If you are filling out this form for Purpose 2 (i.e. enrollment of a Provider Person) please fill out this section providing information only about yourself.

Signature: If this form is being completed for a Provider Entity, the signature below MUST be the written signature of a Responsible Party for the business. If the form is being filled out for a Provider Person the person must sign the form.

+ Definitions & Requirements
24 + Owner, Managing Employee and Controlling Interest Information
+ Real Estate Owners
+ Additional Disclosure
+ Questions

CHANGE OF OPERATOR (PROVIDER)

Step 25: Click 'Add New'

ITEM IV (if you are a sole Provider you will fill out both parts of this item ---
a) is about your employees
b) is about yourself
a. If you are filing out this form for Purpose 1 (i.e. on behalf of the Provider Entity) please list the following:
1. List the name, home address, DOB and SSN of each Person with an Ownership or Control Interest in the Provider Entity or is an Agent or Managing Employee of the Provider Entity;
2. Please list the name, home address, DOB and SSN of each Person with an Ownership or Control Interest in the Provider Entity that has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the title XX services program since the inception of those programs. 42 C.F.R. §455.106 Provider Entities shall search the List of Excluded Individuals/Entities (LEIE) each month for the names of the Providers' Entities' employees and contractors.
b. If you are filing out this form for Purpose 2 (i.e. enrollment of a Provider Person) please fill out this section providing information only about yourself.
Signature: If this form is being completed for a Provider Entity, the signature below MUST be the written signature of a Responsible Party for the business. If the form is being filled out for a Provider Person the person must sign the form.

+ Definitions & Requirements
- Owner, Managing Employee and Controlling Interest Information

No owner information found.

25
Add New

List the name, home address (no P.O. Box addresses), Date of Birth (DOB), Social Security Number (SSN) and percentage owned for each person with a direct or indirect ownership or control interest of 5 percent or more in the provider entity. In addition, list the same information for any subcontractor in which the provider entity has direct or indirect ownership or control interest of 5 percent or more. If you are an individual AND you are a solo practitioner and you own 100 percent of your practice then you would just list yourself as 100% owner.

Thank you for your

Step 26: Fill owner's information and click 'Save'

Owner Information

26

Owner Type* Individual

Owner Title

Affiliation Type

Address 1*

Address 2

City*

State*

County

Zip*

Percentage of Ownership*

Owner End Date 12/31/2299

Save Cancel

CHANGE OF OPERATOR (PROVIDER)

Step 27: Expand the 'Questions' section by clicking the '+' icon and answer additional questions. Then click 'Next'

Note: If 'Yes' is answered to a question, additional details need to be provided

- Questions

27 Are any of the above mentioned persons related to one another as a spouse, parent, child, or sibling?

Yes
 No

Does any person who has an ownership or control interest in this provider entity also have an ownership or control interest with another provider entity?

Yes
 No

Have you or any individuals or organizations having a direct or indirect ownership or controlling interest of 5 percent or more in the professional association or practice, any managing employees or other employees been indicted or convicted of a criminal offense related to the involvement of such persons, or organizations in any of the programs established by Titles XVIII, XIX, or XX?

Yes
 No

Have you as the Provider, or any Owner, Authorized Agent, Associate, Manager, Employee, Directors, or Officers of the Institution, Agency, Organization, or Practice ever been indicted or convicted of a violation of State or Federal Law?

Yes
 No

Step 28: On the Required Documents page, scroll down to locate any required documents Upload documents by clicking 'Browse.' Once all documents have been uploaded, click 'Next'

Uploaded Documents

Please note that you will not be able to delete uploaded documents once your application has been submitted.
No uploaded documents found.

No file chosen

Name:

Description:

Required Document

28 **ODM 03620 ODM 03620**

[SiteVisitPhoto.png_13.png](#) [Download](#) [Remove](#)

Real Estate Documents Real Estate Documents

[SiteVisitChecklist_10.pdf](#) [Download](#) [Remove](#)

Required Documents (490207)

CHANGE OF OPERATOR (PROVIDER)

Step 29: Enter Change of Operator information, which could include the following:

- CHOP Type
- Purchase Price
- Sub-lease Amount
- Total Annual Master Lease Amount
- Effective Date of CHOP

When information has been entered, click 'Next'

Change of Operator Information
This is a required section.

Change of Operator Information

CHOP Type: SALE OR TRANSFER OF OWNERSHIP INTEREST

Exiting Operator Medicaid ID: 0000053

Purchase Price: \$545,000.00

Sub-lease Amount: \$0.00

Total Initial Annual Master Lease Amount: \$0.00

Effective Date of CHOP: 8/12/2022

Step 30: On the Agreements page, agree to the terms by marking the checkboxes as checked

Jump To: Provider Information

Agreements
This is a required section.

Ohio Medicaid Provider Agreement

Note: The Provider Agreement in the scroll box must be read and responded to in its entirety before proceeding to the next step. A failure to check this box shall be taken by OJM to mean that you waive your rights to a retroactive period or months prior to the date OJM approves your application. This agreement is limited to 5 years from the effective date.

If you meet this provision, please check this box

Long Term Care Facility (LTCF) Agreement

Certification Status / Agreement Period The following terms of this agreement are contingent upon continued certification by the Secretary of the U.S. Department of Health and Human Services, or the Ohio Department of Health, which is the state survey agency.

Department Responsibilities This provider agreement is a contract between the Ohio Department of Medicaid (ODM) and the undersigned provider of Medicaid services. ODM shall make

Provider Agreement Attestation

I have read the contents of this application, and the information contained herein is true, correct and complete. I agree to notify Ohio Medicaid of any future changes to the

CHANGE OF OPERATOR (PROVIDER)

Step 31: Fill Provider Agreement Signature fields and click 'Save'

Provider Agreement Signature

Name of Person Attesting*: Tom Trainer

Provider Name: Training Test Nursing Facility

User ID: provadmin

31 Save

Step 32: Click 'Submit for Review' at the top of the screen

Jump To: Provider Information

Nursing Facility Ventilator* W9 Form* Application Fee* Owner Information* Required Documents* Change of Operator Information* Agreements*

Generate PDF

32 Submit for Review

Save Cancel Previous Next

Agreements

This is a required section.

Ohio Medicaid Provider Agreement

Note: The Provider Agreement in the scroll box must be read and responded to in its entirety before proceeding to the next step.

All Providers must read the statements below and agree to the terms

Executive Order 2007-01S Agreement

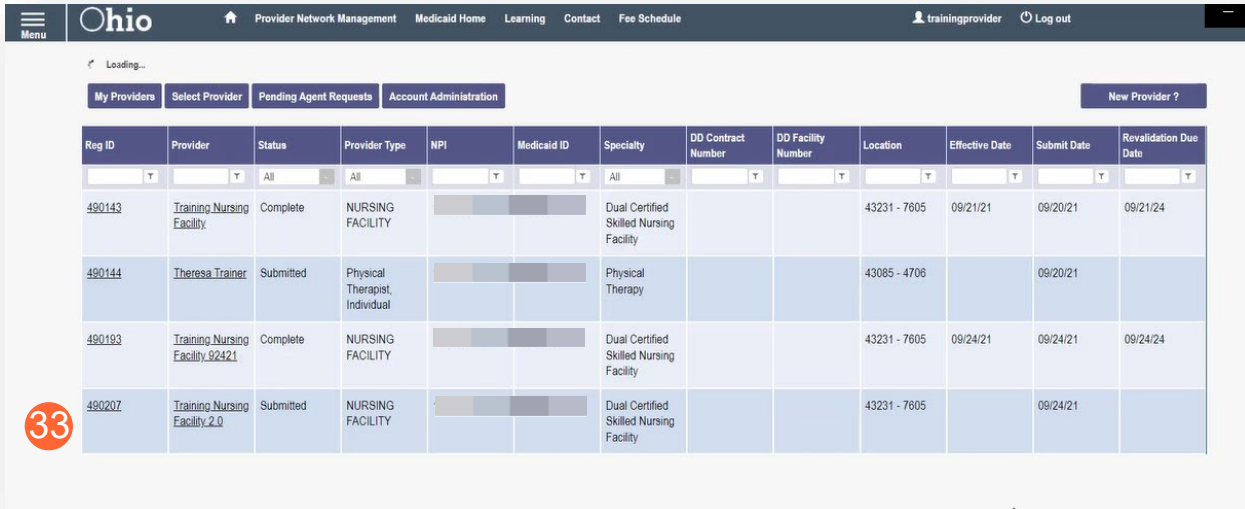
In accordance with Executive Order 2007-01S, Vendor or Grantee, by signature on this document, certifies: (1) it has reviewed and understands Executive Order 2007-01S, (2) it has reviewed and understands the Ohio ethics and conflict of interest laws, and (3) will take no action inconsistent with those laws and this order. The Vendor or Grantee understands that failure to comply with Executive Order 2007-01S is, in itself, grounds for termination of this contract or grant and may result in the loss of other contracts or grants with the State of Ohio. A copy of the Executive Order can be found on our website at: <http://medicaid.ohio.gov/PROVIDERS/EnrollmentandSupport/ProviderEnrollment.aspx>

False Statement Agreement

Whoever knowingly and willfully makes, or causes to be made, a false statement or representation on this statement, may be prosecuted under applicable federal or state laws. In addition, if a person knowingly and willfully fails to fully and accurately disclose the information requested Ohio Department of Medicaid may deny the request to participate or, if the entity already

CHANGE OF OPERATOR (PROVIDER)

Step 33: Return to the homepage to view that the Provider has been submitted.



Ohio Provider Network Management

trainingprovider Log out

Loading...

My Providers Select Provider Pending Agent Requests Account Administration New Provider ?

Reg ID	Provider	Status	Provider Type	NPI	Medicaid ID	Specialty	DD Contract Number	DD Facility Number	Location	Effective Date	Submit Date	Revalidation Due Date
490143	Training Nursing Facility	Complete	NURSING FACILITY			Dual Certified Skilled Nursing Facility			43231 - 7605	09/21/21	09/20/21	09/21/24
490144	Theresa Trainer	Submitted	Physical Therapist, Individual			Physical Therapy			43085 - 4706		09/20/21	
490193	Training Nursing Facility 92421	Complete	NURSING FACILITY			Dual Certified Skilled Nursing Facility			43231 - 7605	09/24/21	09/24/21	09/24/24
490207	Training Nursing Facility 2.0	Submitted	NURSING FACILITY			Dual Certified Skilled Nursing Facility			43231 - 7605		09/24/21	

Confirmation of Building CHOP

Once the CHOP is completed and the new Entering Provider is approved and enrolled, you can verify that the Exiting Provider’s building is associated with the Entering Provider. To do this, click on the Reg ID or Provider name hyperlink on the homepage/dashboard (A).

Reg ID	Provider	Status	Provider Type	NPI	Medicaid ID	Specialty	DD Contract Number	DD Facility Number	Location	Effective Date	Submit Date	Revalidation Due Date
490143	Training Nursing Facility	Complete	NURSING FACILITY	1457921579	9983423	Dual Certified Skilled Nursing Facility			43231 - 7605	09/21/21	09/20/21	09/21/24
490144	Theresa Trainer	Submitted	Physical Therapist, Individual	1841831769		Physical Therapy			43085 - 4706		09/20/21	
490193	Training Nursing Facility_S2421	Complete	NURSING FACILITY	1659593044	9983441	Dual Certified Skilled Nursing Facility			43231 - 7605	09/24/21	09/24/21	09/24/24
490207	Training Nursing Facility_2_0	Submitted	NURSING FACILITY	1780044851		Dual Certified Skilled Nursing Facility			43231 - 7605		09/24/21	

On the Provider Management Home page, expand the Self Service section by clicking the ‘+’ icon. Click ‘View Provider File’ (B).

Self Service

- Self Service Selections:**
 - [View Provider File](#)
 - [Provider Correspondence](#)
 - [Remittance Advice](#)
 - [Recipient Eligibility](#)
 - [Claims](#)
 - [Prior Authorization](#)
 - [Cost Reports and Rate Setting](#)
 - [Hospice](#)
 - [Payment Innovation Reports](#)
 - [Attachments](#)

CHANGE OF OPERATOR (PROVIDER)

You can find the Building Medicaid ID by searching for the Entering Provider- in the header information (C).

Ohio [Provider Network Management](#) [Medicaid Home](#) [Learning](#) [Contact](#) [Fee Schedule](#) lisachop [Log out](#)

Provider Name		Medicaid ID		NPI	
Provider Type	NURSING FACILITY	Risk Level	Limited	Effective Date	08/18/2021
Application Type	Change of Operator	Enrollment Type	New	Revalidation Date	08/18/2024
Application Status	Complete				
Enrollment Status	ACTIVE	Reason Code	ACTIVE		
C Building Medicaid ID	175117541				

[Email](#) [Notes](#) [Less...](#)

Jump To:

Provider Information* → Primary Contact Information* → Credentialing Contact → Office Information → Primary Service Address* → Billing & Payment Address*

[Generate PDF](#)

Provider Information

[Next](#)

Name of Business Entity*

DBA*