



NOTICE OF INTENT TO CONVERT

Complete for a change in designation. A change in designation does not require submission of a new licensure application. Completion of this form serves as notice to the Health Facilities Commission.

Facility name: _____

License #: _____

Please select from below the licensure category designation to which your facility will convert -

- In-state provider with a physical location
- In-state provider without a physical location
- Out-of-state provider without a physical location
- Mail order company

Based upon the facility's change in licensure category designation, please provide change information for any applicable item listed below and a secure online portal access. The secure online portal access is required for all out of state facilities in order to conduct all necessary and required licensure surveys. If there is not a change, please indicate such by placing 'same' in the line following that item.

New Address/Location: _____

Administrator/Contact: _____

Administrator/Contact Email: _____

Administrator/Contact Phone: _____

Secure Online Portal Access: _____