BRITISH COLUMBIA | Ministry of Health

DIAGNOSTIC FACILITIES ADMINISTRATION

FORM E: APPLICATION FOR TRANSFER OF MATERIAL FINANCIAL INTEREST OF AN EXISTING PRIVATELY OWNED DIAGNOSTIC FACILITY

This application is solely for the transfer of material financial interest (an interest of more than 10% of the shares in a corporation, partnership or association).

For all other applications, please review information available at: http://www.gov.bc.ca/diagnosticfacilitiescommittee

IMPORTANT APPLICANT INFORMATION

Any publicly or privately-owned Diagnostic Facility in British Columbia intending to bill the British Columbia Medical Services Plan (MSP) for outpatient diagnostic services must obtain a Certificate of Approval, granted by the Advisory Committee on Diagnostic Facilities (ACDF) or the Medical Services Commission (MSC).

All Certificates of Approval are **site- and owner-specific and cannot be transferred or assigned**. If a facility is sold, the new owner must apply for a new Certificate of Approval in order to bill MSP for the provision of outpatient services.

Approval from the ACDF/MSC is required in order to bill MSP for the following outpatient services:

- Diagnostic Radiology
- Diagnostic Ultrasound
- Nuclear Medicine
- Polysomnography
- Pulmonary Function
- Electromyography (EMG)
- Electroencephalography (EEG)

Once an application is approved, the applicant must ensure all required facility accreditation and practitioner credentialing is in place prior to billing MSP for outpatient services.

HOW TO COMPLETE AND SUBMIT THIS APPLICATION

Applicants should complete the entire application, including the Conflict of Interest Declaration and Disclosure, in as much detail as possible. Additional pages should be added and uploaded along with an application, where additional space is required to provide complete information (please clearly indicate which questions/information you are providing additional information on). **When complete and authorized, the application must be submitted through the Ministry of Health's secure upload tool located at:** https://www2.gov.bc.ca/submitacdf

For detailed information on the ACDF and other applications, see the ACDF User Guide to Applications for New, Expansion or Relocation of Private Outpatient Services, at: http://www.gov.bc.ca/diagnosticfacilitiescommittee

For more information on the application and assessment process and the policies that govern it, it is recommended that all applicants review the Policies and Guidelines of the Medical Services Commission's Advisory Committee on Diagnostic Facilities, at: http://www.gov.bc.ca/diagnosticfacilitiespolicies

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FORM E: TRANSFER OF MATERIAL FINANCIAL INTEREST

Application Date (YYYY / MM / DD)

TYPE OF SERVICE

(A) Approved Type of Service

Please specify below the approved type of facility service. **Please note that due to the distinct criteria used to assess each type of application, please reference only ONE modality per application.**

- ◯ Polysomnography
- ◯ Pulmonary Function
  (Category III and IV services restricted to public facilities)
- ◯ Radiology
  (if applicable, please specify the Category and/or Fee Item in Section (B).)
  - ☐ Bone Density
  - ☐ Digital Breast Tomosynthesis
- ◯ Ultrasound
  (if applicable, please specify the Category and/or Fee Item in Section (B).)
  - ☐ Nuchal Translucency

(B) Current Approved Category(s) of Tests or Fee Item(s)

Category(ies) of Tests	Fee Item(s) (if applicable)

DIAGNOSTIC FACILITY INFORMATION

Diagnostic Facility Name	Diagnostic Facility Number	Diagnostic Facility Payment Number
Diagnostic Facility Location (street address, city, postal code)		
Diagnostic Facility Mailing Address (if different from above)		
Medical Director Responsible for Onsite Diagnostic Service(s) Referenced in Application	Department	
Email	Phone	

FORM E: TRANSFER OF MATERIAL FINANCIAL INTEREST

CURRENT OWNERSHIP INFORMATION

Ownership

◯ Sole Ownership ◯ Partnership or Association ◯ Corporation ◯ Other (specify):

Please fill out the applicable section below relating to which button was checked.

Sole Ownership

Owner Name

Owner Business Address

Partnership or Association (please list each partner, associate or financial beneficiary; append listing if required)

Name of Partner/Associate/Financial Beneficiary	Business Address	Percentage Owned

Corporation (please provide the full name, business address and corporate title for all Officers and Directors; append listings if required)

Corporation Name	Corporation No.	Date of Incorporation

Name of Officer/Director	Business Address	Title

Name of Shareholder(s)	Address	Percentage Interest

FORM E: TRANSFER OF MATERIAL FINANCIAL INTEREST

Effective Date (YYYY / MM / DD)

PROPOSED OWNERSHIP INFORMATION

Ownership

◯ Sole Ownership ◯ Partnership or Association ◯ Corporation ◯ Other (specify):

Please fill out the applicable section below relating to which button was checked.

Sole Ownership

Owner Name

Owner Business Address

Partnership or Association (please list each partner, associate or financial beneficiary; append listing if required)

Name of Partner/Associate/Financial Beneficiary	Business Address	Percentage Owned

Corporation (please provide the full name, business address and corporate title for all Officers and Directors; append listings if required)

Corporation Name	Corporation No.	Date of Incorporation

Name of Officer/Director	Business Address	Title

Name of Shareholder(s)	Address	Percentage Interest

FOREIGN INTEREST

Is the proposed diagnostic facility that is the subject of this application owned, in whole or in part, for a foreign interest?
For the purpose of this application, foreign interest means: any form of business enterprise or legal entity organized, chartered, or incorporated under the laws of a country other than Canada, or a person who is not a citizen or national of Canada.

◯ Yes ◯ No

Note: Applications involving a foreign interest are subject to ACDF policy 2.4.5 *Assessment Criteria: Compliance with Canadian and BC Law*, and may require additional actions from applicant. For further information, see the ACDF policy document at: http://www.gov.bc.ca/diagnosticfacilitiespolicies or contact Diagnostic Facilities Administration through DFAdmin@gov.bc.ca

CONTACT INFORMATION

Primary Contact Information	Alternate Contact Information
Name	Name
Title	Title
Email	Email
Phone Number	Phone Number

CONFLICT OF INTEREST

Appendix A (Conflict of Interest Declaration) and Appendix B (Conflict of Interest Disclosure) must be completed and submitted with the application in order for this application to be considered. For the relevant policies, see Policy 2.4.4 of the *Policies and Guidelines of the Medical Services Commission's Advisory Committee on Diagnostic Facilities* and the *Diagnostic Facility Conflict of Interest Policy* at http://www.gov.bc.ca/diagnosticfacilitiespolicies

Are Appendix A and Appendix B included with this application? ◯ Yes ◯ No

On behalf of the Diagnostic Facility herein making application, the authorized signatures to this application hereby give a written undertaking that the stipulations of the Medicare Protection Act and the Medical and Health Care Services Regulation shall be applicable to, and are accepted by, the Diagnostic Facility.

Witness
Name (PRINT)
Date
Signature

Transferee (New Owner)
Name (PRINT)
Date
Signature

Witness
Name (PRINT)
Date
Signature

Transferrer (Present Owner)
Name (PRINT)
Date
Signature

APPENDIX A: CONFLICT OF INTEREST DECLARATION

To: Secretariat and Chair, ACDF

I have read and understood the Diagnostic Facility Conflict of Interest Policy (the "Policy"), and I undertake to be bound by the obligations contained therein.

I understand that it is my responsibility to report to the ACDF the information described in the Policy, and I undertake to do so.

I understand that the information I disclose will be held by the ACDF and that the information may be shared with members of the Medical Services Commission, as necessary.

I agree to inform the ACDF of any change in circumstances that may give rise to a conflict of interest with respect to a diagnostic facility, as soon as it is practicable.

ATTENTION: The person completing/signing this Declaration Form (the "Declarant") must be duly authorized to make the declaration on behalf of the person/entity submitting an application.

Name of diagnostic facility to which this conflict of interest declaration is in respect of:

SIGNATURE **If Publicly Owned Facility: CEO of Health Authority or Agency*** **If Privately Owned Facility: Owner of Facility**
Name
Title
Date
Signature

** or formally authorized designate*

APPENDIX B: CONFLICT OF INTEREST DISCLOSURE

To: Secretariat and Chair, ACDF

Is there a (potential) conflict of interest to disclose in relation to the diagnostic facility? Check one:

- ◯ Yes, there is a (potential) conflict of interest to disclose in relation to the diagnostic facility. If yes, provide details of the (potential) conflict of interest in Parts I and II of Appendix B.
- ◯ I am unsure if the circumstances constitute, or may constitute, a (potential) conflict of interest. If unsure, provide details of the (potential) conflict of interest in Parts I and II of Appendix B.
- ◯ No, there is no conflict to interest to disclose in relation to the diagnostic facility.

If no conflict of interest is indicated, Appendix B must be completed by signing and completing the Appendix B signature block information.

ATTENTION: The person completing/signing this Disclosure Form (the "Declarant") must be duly authorized to make the declaration/ disclosure on behalf of the subject person/entity; that is the person who owns or intends to own the diagnostic facility (as applicable).

If applicable, provide full detail and circumstances that relate to potential conflicts of interest by completing Parts I and II.

APPENDIX B PART I

Append additional pages as necessary, to provide all relevant information.

Diagnostic Facility Name(s)	List the names of all relevant practitioners, family members, diagnostic facility owners (including the declarant) or business associates who hold or may hold a relevant financial or material interest	Any relevant affiliations or relationships with the owner or intended owner of the diagnostic facility and the details of any interest or benefit that may relate to a conflict of interest	Any other information, including dates, that is relevant to understanding and assessing the nature, scope and degree/extent of potential conflicts of interest

APPENDIX B PART II

In the space below, provide any additional information (not covered in Part I) that is relevant to understanding and assessing the nature, scope and degree/extent of potential conflicts of interest. Include any detail regarding proposed avoidance or mitigation measures relating to any actual or potential conflicts of interest. Append additional pages as necessary to provide all relevant information.

Name of diagnostic facility to which this conflict of interest disclosure is in respect of:

SIGNATURE **If Publicly Owned Facility: CEO of Health Authority or Agency*** **If Privately Owned Facility: Owner of Facility**
Name
Title
Date
Signature

** or formally authorized designate*

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