

NOTICE OF MATERIAL CHANGE

Date of Notice: _____

1. Name: _____

2. Federal TAX ID #	MA DPH Facility ID #	NPI #
_____	_____	_____

Contact Information

3. Business Address 1: _____

4. Business Address 2: _____

5. City: _____ State: _____ Zip Code: _____

6. Business Website: _____

7. Contact First Name: _____ Contact Last Name: _____

8. Title: _____

9. Contact Phone: _____ Extension: _____

10. Contact Email: _____

Description of Organization

11. *Briefly* describe your organization.

Type of Material Change

12. Check the box for the type of Material Change proposed, as delineated at 958 CMR 7.03(1). Brief descriptions are included here for convenience. Review the [regulation](#) for full details.

- ☐ a) Corporate Affiliation involving a Provider or Provider Organization and a Carrier
- ☐ b) Merger with or Acquisition of a Hospital or hospital system
- ☐ c) Corporate or Contracting Affiliation or employment of Health Care Professionals resulting in an increase of Net Patient Service Revenue equal to or greater than the Revenue Increase Threshold or in a Provider or Provider Organization having Dominant Market Share
- ☐ d) Clinical Affiliation
- ☐ e) Formation of an organization for contracting or administering contracts with Carriers or Third-Party Administrators
- ☐ f) Significant increase to a Provider or Provider Organization's capacity
- ☐ g) Transaction involving a Significant Equity Investor
- ☐ h) Significant acquisitions, sales, or transfers of a Provider or Provider Organization's assets
- ☐ i) Conversion of a Provider or Provider Organization from a non-profit Entity to a for-profit Entity

13. What is the proposed effective date of the proposed Material Change? _____

Material Change Narrative

14. *Briefly* describe the nature and objectives of the proposed Material Change, including any exchange of funds between the parties (such as any arrangement in which one party agrees to furnish the other party with a discount, rebate, or any other type of refund or remuneration in exchange for, or in any way related to, the provision of Health Care Services) and whether any changes in Health Care Services are anticipated in connection with the proposed Material Change:

15. *Briefly* describe the anticipated impact of the proposed Material Change, including but not limited to any anticipated impact on reimbursement rates, care referral patterns, access to needed services, and/or quality of care:

Development of the Material Change

16. Describe any other Material Changes you anticipate making the next 12 months:

17. Indicate the date and nature of any applications, forms, notices or other materials you have submitted regarding the proposed Material Change to any other state or federal agency:

Supplemental Materials

18. Submit the following materials, if applicable, under separate cover to HPC-Notice@mass.gov.

The Health Policy Commission shall keep confidential all nonpublic information, as requested by the parties, in accordance with M.G.L. c. 6D, § 13(c), as amended by 2013 Mass. Acts, c. 38, § 20 (July 12, 2013).

- a. Copies of all current agreement(s) (with accompanying appendices and exhibits) governing the proposed Material Change (e.g., definitive agreements, affiliation agreements);
- b. A current organizational chart of your organization; and
- c. Any analytic support for your responses to Questions 14 and 15 above

This signed and notarized Affidavit of Truthfulness and Proper Submission is required for a complete submission.

Affidavit of Truthfulness and Proper Submission

I, the undersigned, certify that:

1. I have read 958 CMR 7.00, Notices of Material Change and Cost and Market Impact Reviews.
2. I have read this Notice of Material Change and the information contained therein is accurate and true.
3. I have submitted the required copies of this Notice to the Health Policy Commission, the Office of the Attorney General, and the Center for Health Information and Analysis as required.

Signed on the 14th day of August, 2026, under the pains and penalties of perjury.

Signature: _____

Name: _____

Title: _____

FORM MUST BE NOTARIZED IN THE SPACE PROVIDED BELOW:



Notary Signature

Copies of this application have been submitted electronically as follows:

Office of the Attorney General (1)

Center for Health Information and Analysis (1)