

AMBULATORY CARE APPLICATION FOR LICENSURE

1. GENERAL INFORMATION

CHECK TYPE OF LICENSE

	AGENCY TYPE	CODE OF MARYLAND REGULATIONS (COMAR)	LICENSE DURATION
<input type="checkbox"/>	Ambulatory Surgery Center	10.05	3 years
<input type="checkbox"/>	Birthing Center	10.05	3 years
<input type="checkbox"/>	Comprehensive Outpatient Rehabilitation Facility	10.07.18	1 year
<input type="checkbox"/>	End Stage Renal Disease Provider	10.05	3 years
<input type="checkbox"/>	Home Health Agency	10.07.10	1 year
<input type="checkbox"/>	Hospice Agency	10.07.21	1 year
<input type="checkbox"/>	Major Medical Equipment Provider	10.05	3 years
<input type="checkbox"/>	Nursing Referral Service Agency	10.07.07	3 years
<input type="checkbox"/>	Nursing Staff Agency	10.07.03	1 year
<input type="checkbox"/>	Residential Service Agency (RSA) – Others	10.07.05	1 year
<input type="checkbox"/>	RSA – Skilled Nursing and Aides Only	10.07.05	1 year
<input type="checkbox"/>	Surgical Abortion Facility	10.12.01	3 years

CHECK TYPE OF APPLICATION

Initial Renewal Other Changes (specify)

LEGAL AGENCY NAME			TRADING NAME (DBA)			
E-MAIL ADDRESS			PHONE NUMBER		FAX NUMBER	
BUSINESS ADDRESS (physical location)			MAILING ADDRESS (if different)			
NUMBER, STREET			NUMBER, STREET			
CITY		STATE	ZIP	CITY		STATE ZIP
COUNTY			LICENSE NUMBER (if applicable)			
NAME OF ADMINISTRATOR (Last, First, Middle Initial)			AFTER HOURS/EMERGENCY CONTACT NUMBER			
BUSINESS HOURS (in HH:MM format)						
	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY SATURDAY
FROM:						
TO:						

2. FEES

To determine the amount of the **non-refundable** license fee and accepted methods of payment, refer to the instruction guide.

FEE ATTACHED? Yes

3. OWNERSHIP (Type of business organization of disclosing entity)

SOLE PROPRIETORSHIP PARTNERSHIP CORPORATION

NAME	ADDRESS
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NAME(S), TITLE(S), AND ADDRESS(ES) OF PARTNER(S) AND PERCENTAGE OWNED IF 2% OR MORE
(Attach additional pages if needed.)

NAME AND TITLE	ADDRESS	PERCENTAGE OWNED

IF CORPORATION: DATE OF CHARTER		DATE OF INCORPORATION	FEIN NUMBER	
NAME OF PRESIDENT		PHONE NUMBER	CELL NUMBER	
ADDRESS (number, street)		CITY	STATE	ZIP

4. BACKGROUND

- Has any owner, officer, director, agency, or managerial staff had a license revoked, suspended, or denied by the DHMH within the last five years? No Yes (explain)
- Does the parent company, owner, agent, officer, or managerial staff own or operate a health care facility/agency licensed or surveyed by the OHCQ? No Yes (explain)
- The agency hereby attests that it is in compliance with The Civil Rights Act of 1964; The Rehabilitation Act of 1973; The Americans with Disabilities Act of 1990; and The Drug Free Workplace Act of 1988. Yes No (explain)
- Have the owners, officers, directors, agents, or managerial staff been convicted of a criminal offense involving any program under Title 18, 19, or 20 of the Social Security Act? No Yes

5. WORKERS' COMPENSATION

Do you have any employees? Yes No

If you answered YES, provide your workers' compensation insurance information:

POLICY NUMBER	BINDER NUMBER
INSURANCE COMPANY	EFFECTIVE DATE
	EXPIRATION DATE

If you answered NO, additional documentation from the Workers' Compensation Commission must accompany this application (refer to the instruction guide for details).

6. AMBULATORY SURGERY CENTER

DAYS AND HOURS THE OFFICE MANAGER IS ON-SITE (in HH:MM format)

	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
FROM:							
TO:							

BACK-UP GENERATOR <input type="checkbox"/> Yes <input type="checkbox"/> No	DAYS OR IS USED <input type="checkbox"/> Sunday <input type="checkbox"/> Monday <input type="checkbox"/> Tuesday <input type="checkbox"/> Wednesday <input type="checkbox"/> Thursday <input type="checkbox"/> Friday <input type="checkbox"/> Saturday
NUMBER OF OPERATING/PROCEDURE ROOMS	NAME OF MEDICAL DIRECTOR
ACCREDITED <input type="checkbox"/> Yes <input type="checkbox"/> No	ACCREDITING AGENCY
	DATE OF ACCREDITATION
DEEMED STATUS <input type="checkbox"/> Yes <input type="checkbox"/> No	DEEMING AGENCY
	DATE OF DEEMED STATUS

IDENTIFY ALL SPECIALTIES PROVIDED

<input type="checkbox"/> Cardiovascular	<input type="checkbox"/> Neurological	<input type="checkbox"/> Otolaryngology	<input type="checkbox"/> Urology
<input type="checkbox"/> Colon and Rectal	<input type="checkbox"/> OB/GYN	<input type="checkbox"/> Pain Management	<input type="checkbox"/> Other (specify)
<input type="checkbox"/> Endoscopy	<input type="checkbox"/> Ophthalmology	<input type="checkbox"/> Plastic Surgery	
<input type="checkbox"/> GI Procedures	<input type="checkbox"/> Oral	<input type="checkbox"/> Podiatric	
<input type="checkbox"/> General	<input type="checkbox"/> Orthopedic	<input type="checkbox"/> Thoracic	
<input type="checkbox"/> Lower GI Procedures	<input type="checkbox"/> Other GI Procedures	<input type="checkbox"/> Upper GI	

IDENTIFY ALL MAJOR MEDICAL EQUIPMENT UTILIZED IN THE AMBULATORY SURGERY CENTER

<input type="checkbox"/> Cardiac Catheterization Equipment	Quantity:	<input type="checkbox"/> Magnetic Resonance Imager	Quantity:
<input type="checkbox"/> Computer Tomography Equipment	Quantity:	<input type="checkbox"/> Lithotripter	Quantity:
<input type="checkbox"/> Radiation Therapy Equipment	Quantity:		

7. BIRTHING CENTER

NAME OF MEDICAL DIRECTOR	NAME OF DIRECTOR OF MIDWIFERY SERVICES
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8. COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY

DATE OF ACCREDITATION BY THE COMMISSION ON ACCREDITATION OF REHABILITATION FACILITIES	NAME OF MEDICAL DIRECTOR
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CORE SERVICES PROVIDED	OTHER SERVICES PROVIDED
<input type="checkbox"/> Physical Therapy <input type="checkbox"/> Physician <input type="checkbox"/> Psychological <input type="checkbox"/> Social	<input type="checkbox"/> Licensed Practical Nurse <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Orthotist <input type="checkbox"/> Prosthetist <input type="checkbox"/> Registered Nurse <input type="checkbox"/> Rehabilitation Counselor <input type="checkbox"/> Respiratory Therapist <input type="checkbox"/> Speech Language Pathologist

9. END STAGE RENAL DISEASE PROVIDER

DIALYSIS SERVICES PROVIDED		
<input type="checkbox"/> HEMODIALYSIS	<input type="checkbox"/> HOME TRAINING - HEMODIALYSIS/PERITONEAL DIALYSIS	
<input type="checkbox"/> PERITONEAL DIALYSIS	<input type="checkbox"/> HOME SUPPORT - HEMODIALYSIS/PERITONEAL DIALYSIS	
<input type="checkbox"/> TRANSPLANTATION		
IS REUSE PRACTICED	ISOLATION ROOM	BACK-UP GENERATOR
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
NUMBER OF DIALYSIS STATIONS AT THIS LOCATION	NAME OF MEDICAL DIRECTOR	

DO YOU PROVIDE KIDNEY DIALYSIS SERVICES IN A NURSING FACILITY OR SKILLED NURSING FACILITY? No Yes (list facility names)

10. HOME HEALTH AGENCY

NAME AND ADDRESS OF PARENT AGENCY IF DIFFERENT FROM LICENSED AGENCY		
ACCREDITED	ACCREDITING AGENCY	DATE OF ACCREDITATION
<input type="checkbox"/> Yes <input type="checkbox"/> No		
DEEMED STATUS	DEEMING AGENCY	DATE OF DEEMED STATUS
<input type="checkbox"/> Yes <input type="checkbox"/> No		
PATIENT POPULATION(S) SERVED		
<input type="checkbox"/> Adult	<input type="checkbox"/> Pediatric	<input type="checkbox"/> Other (list)
<input type="checkbox"/> Maternal/Child Health	<input type="checkbox"/> Psychiatric	

SERVICES	SERVICE PROVIDED			CONTRACTOR'S NAME
	DIRECTLY	THROUGH CONTRACT	DIRECTLY & THROUGH CONTRACT	
SKILLED NURSING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
HOME HEALTH AIDES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
PHYSICAL THERAPY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
SPEECH LANGUAGE PATHOLOGY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
OCCUPATIONAL THERAPY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
MEDICAL SOCIAL SERVICES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
INFUSION SERVICES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
LIST OTHER SERVICES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

NUMBER OF UNDUPLICATED ADMISSIONS FOR THE LAST FISCAL YEAR	NAME OF NURSING SUPERVISOR
NAME OF SERVICE DIRECTOR	NAME OF SERVICE DIRECTOR DESIGNEE

11. HOSPICE AGENCY

TYPE OF AGENCY General Limited

JURISDICTIONS/COUNTIES SERVED Allegany Anne Arundel Baltimore City Baltimore County Calvert Caroline Carroll Cecil Charles Dorchester Frederick Garrett Harford Howard Kent Montgomery Prince George's Queen Anne's Somerset St. Mary's Talbot Washington Wicomico Worcester

DOES THE AGENCY OPERATE/OWN HOSPICE HOUSES? NO YES (list below) NUMBER OF HOUSES

UNIT ADDRESS	PHONE NUMBER	NUMBER OF BEDS

DOES THE AGENCY OPERATE A HOSPICE-OWNED INPATIENT UNIT? NO YES (list below)

UNIT ADDRESS	PHONE NUMBER	NUMBER OF BEDS

ACCREDITED <input type="checkbox"/> Yes <input type="checkbox"/> No	ACCREDITING AGENCY	DATE OF ACCREDITATION
DEEMED STATUS <input type="checkbox"/> Yes <input type="checkbox"/> No	DEEMING AGENCY	DATE OF DEEMED STATUS

NAME OF DIRECTOR NAME OF MEDICAL DIRECTOR

12. MAJOR MEDICAL EQUIPMENT PROVIDER

IDENTIFY ALL MAJOR MEDICAL EQUIPMENT UTILIZED

	EQUIPMENT TYPE	NUMBER OF EQUIPMENT	SETTING (ASC, HOSPITAL, ETC)
<input type="checkbox"/>	CARDIAC CATHETERIZATION EQUIPMENT		
<input type="checkbox"/>	COMPUTER TOMOGRAPHY EQUIPMENT		
<input type="checkbox"/>	LITHOTRIPTER		
<input type="checkbox"/>	RADIATION THERAPY EQUIPMENT		
<input type="checkbox"/>	MAGNETIC RESONANCE IMAGER		

IS ANY OF THE ABOVE EQUIPMENT OPERATED AS A MOBILE UNIT? NO YES (list the equipment and number of vehicles involved)

NAME OF MEDICAL DIRECTOR

13. NURSING STAFF AGENCIES

IDENTIFY ALL HEALTHCARE FACILITIES STAFF WILL BE REFERRED TO

14. RSA - OTHERS

HOME CARE SERVICES TO BE PROVIDED (check all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Durable Medical Equipment | <input type="checkbox"/> Medical Social Services | <input type="checkbox"/> Skilled Nursing |
| <input type="checkbox"/> Durable Medical Equipment w/ Oxygen | <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Speech Therapy |
| <input type="checkbox"/> Intravenous or Related Therapies | <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Ventilator Services |

CATEGORY

- For Profit Non Profit

IF DME, ACCREDITED

- Yes No

IF DME, ACCREDITING AGENCY

IF DME, DATE OF ACCREDITATION

15. RSA - SKILLED NURSING & AIDES ONLY

HOME CARE SERVICES TO BE PROVIDED (check only one level of care)

- Level One: RN supervision of Aides without medication management
- Level Two: RN supervision of Aides with medication management
- Level Three: Complex care provided by RN, LPN and RN supervision of Aides (e.g. Wound Care, Tube Feeding, Trach Care, Vent Management, Intravenous or Related Therapies, etc.)

CATEGORY

- For Profit Non Profit

LIST THE TYPE(S) OF COMPLEX CARE TO BE PROVIDED BY YOUR AGENCY

16. SURGICAL ABORTION FACILITY

DAYS AND HOURS THE OFFICE MANAGER IS ON-SITE (in HH:MM format)

	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
FROM:							
TO:							

BACK-UP GENERATOR

- Yes No

DAYS OR IS USED

- Sunday Monday Tuesday Wednesday Thursday Friday Saturday

NUMBER OF OPERATING/PROCEDURE ROOMS

NAME OF MEDICAL DIRECTOR

ACCREDITED

- Yes No

ACCREDITING AGENCY

DATE OF ACCREDITATION

IDENTIFY ALL MAJOR MEDICAL EQUIPMENT UTILIZED

- | | | | |
|--|-----------|--|-----------|
| <input type="checkbox"/> Cardiac Catheterization Equipment | Quantity: | <input type="checkbox"/> Magnetic Resonance Imager | Quantity: |
| <input type="checkbox"/> Computer Tomography Equipment | Quantity: | <input type="checkbox"/> Lithotripter | Quantity: |
| <input type="checkbox"/> Radiation Therapy Equipment | Quantity: | | |

17. AFFIDAVIT

I solemnly affirm under the penalties of perjury and upon personal knowledge that the contents of the foregoing application are true. I understand that the falsification of an application for a license may subject me to criminal prosecution, civil money penalties, and/or the revocation of any license issued to me by the DHMH. In addition, knowingly and willfully failing to fully and accurately disclose the requested information may result in denial of a request to become licensed or, where the entity already is licensed, a revocation of that license.

I certify that this agency is in compliance with administrative and procedural requirements pertaining to the Code of Maryland Regulations (COMAR) checked below.

I further certify that I will notify the OHCC if there are any future substantive changes in agency and operation, and

that written notice will be given before the effective date of the change.

I hereby swear and affirm that I am over the age of 21 and I am otherwise competent to sign this Affidavit.

If the program is going to be in more than one applicant's name, each applicant's signature is required.

Governing Regulations:

- | | |
|--|---|
| <input type="checkbox"/> Ambulatory Surgery Center – COMAR 10.05 | <input type="checkbox"/> Major Medical Equipment Provider - COMAR 10.05 |
| <input type="checkbox"/> Birthing Center – COMAR 10.05 | <input type="checkbox"/> Nursing Referral Service Agency – COMAR 10.07.07 |
| <input type="checkbox"/> Comprehensive Outpatient Rehabilitation Facility – COMAR 10.07.18 | <input type="checkbox"/> Nursing Staff Agencies – COMAR 10.07.03 |
| <input type="checkbox"/> End Stage Renal Disease Provider – COMAR 10.05 | <input type="checkbox"/> Residential Service Agencies – Others – COMAR 10.07.05 |
| <input type="checkbox"/> Home Health Agency – COMAR 10.07.10 | <input type="checkbox"/> Residential Service Agencies – Skilled Nursing and Aides Only – COMAR 10.07.05 |
| <input type="checkbox"/> Hospice Agency – COMAR 10.07.21 | <input type="checkbox"/> Surgical Abortion Facility – COMAR 10.12.01 |

SIGNATURE OF APPLICANT	TITLE	DATE
SIGNATURE OF APPLICANT	TITLE	DATE
SIGNATURE OF APPLICANT	TITLE	DATE
SIGNATURE OF APPLICANT	TITLE	DATE

FOR OFFICE USE ONLY			
INITIALS	DATE	AMOUNT PAID	CHECK NUMBER
DATE OF CHECK	BANK		

20. ADDENDUM - RSA ANNUAL DATA COLLECTION SURVEY

1. LICENSED NAME	CURRENT RSA LICENSE NUMBER		
NUMBER, STREET	CITY	STATE	ZIP
CONTACT PERSON	TITLE	PHONE NUMBER	
PERSON COMPLETING SURVEY	DATE SURVEY COMPLETED	PHONE NUMBER	
2. The requested information reported in this survey is for the past 12-month period.	BEGINNING DATE	ENDING DATE	

If you are not reporting data for a complete 12-month period, select the appropriate response:
 Newly established RSA RSA closed Change in ownership Other:

3. Which of the following services were consistently provided to clients by your RSA staff during this 12-month period? (check appropriate boxes)

SERVICES PROVIDED	YES	NO	SERVICES PROVIDED	YES	NO
Skilled Nursing	<input type="checkbox"/>	<input type="checkbox"/>	Intravenous or Related Therapies	<input type="checkbox"/>	<input type="checkbox"/>
Personal Care Services	<input type="checkbox"/>	<input type="checkbox"/>	Medical Social Work	<input type="checkbox"/>	<input type="checkbox"/>
Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Ventilator Services	<input type="checkbox"/>	<input type="checkbox"/>
Speech Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Dietary and Nutritional Consultation	<input type="checkbox"/>	<input type="checkbox"/>
Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Durable Medical Equipment	<input type="checkbox"/>	<input type="checkbox"/>
Homemaker/Chore	<input type="checkbox"/>	<input type="checkbox"/>	Oxygen	<input type="checkbox"/>	<input type="checkbox"/>
Transportation	<input type="checkbox"/>	<input type="checkbox"/>	Other (specify):	<input type="checkbox"/>	<input type="checkbox"/>
Laboratory	<input type="checkbox"/>	<input type="checkbox"/>	Other (specify):	<input type="checkbox"/>	<input type="checkbox"/>

4. Report the number of full-time (FT) and part-time (PT) employees during this 12-month period. Include support staff, maintenance techs, supervisor personnel, and independent contractors under agreement with your agency.

TYPE OF PERSONNEL	FT	PT	TYPE OF PERSONNEL	FT	PT
Administrative			Speech Therapists (ST)		
Registered Nurses (RNs)			Respiratory Therapists (RT)		
Licensed Practical Nurses (LPNs)			Home Health Aides		
Certified Nurse Aides (CNAs)			Medical Social Workers (MSW)		
Geriatric Nurse Aides (GNAs)			Homemakers		
Medication Technicians			Companions		
Physical Therapists (PT)			Drivers		
Occupational Therapists (OT)			Other (specify):		
TOTAL FULL-TIME PERSONNEL			TOTAL PART-TIME PERSONNEL		

The numerical responses to questions 5 through 10 should not include companion care clients or clients provided services outside of the State of Maryland.

Key: Group A – Patients that require care from a RN, LPN, PT, OT, ST, RT, MSW, etc.

Group B – Patients that require an RN assessment but receive care from a CNA, GNA, Aide, Med Tech, etc.

Group C – DME/Oxygen Clients

5. Report the total number of admissions and discharges in the 12 month period:

	GROUP A	GROUP B	GROUP C
ADMISSIONS			
DISCHARGES			

6. AGENCY'S CURRENT CENSUS

7. Number of clients in each jurisdiction to whom your RSA provided services to during this reporting period. Refer to the above key for differences between Group A and Group B.

Jurisdiction/County	Enter Number of Group A Clients (By Age Group) Your Company Provided Services To						Enter Number of Group B Clients (By Age Group) Your Company Provided Services To					
	0-14	15-44	45-64	65-74	75-84	85+	0-14	15-44	45-64	65-74	75-84	85+
Allegany												
Anne Arundel												
Baltimore City												
Baltimore County												
Calvert												
Caroline												
Carroll												
Cecil												
Charles												
Dorchester												
Frederick												
Garrett												
Harford												
Howard												
Kent												
Montgomery												
Prince George's												
Queen Anne's												
Somerset												
St. Mary's												
Talbot												
Washington												
Wicomico												
Worcester												
TOTAL												

8. Number of Group C (DME/Oxygen) clients in each jurisdiction to whom your RSA provided services to during this reporting period. (If applicable.)

JURISDICTION/COUNTY	NUMBER OF CLIENTS	JURISDICTION/COUNTY	NUMBER OF CLIENTS	JURISDICTION/COUNTY	NUMBER OF CLIENTS
Allegany		Charles		Prince George's	
Anne Arundel		Dorchester		Queen Anne's	
Baltimore City		Frederick		Somerset	
Baltimore County		Garrett		St. Mary's	
Calvert		Harford		Talbot	
Caroline		Howard		Washington	
Carroll		Kent		Wicomico	
Cecil		Montgomery		Worcester	
TOTAL					

9. Are you licensed to, or do you, provide care in any other State or in the District? No Yes (list)

10A. Number of clients, by payer source, served during this reporting period.

PAYER SOURCE	NUMBER OF RSA CLIENTS	PAYER SOURCE	NUMBER OF RSA CLIENTS
*Medicaid		Self Pay	
*Other Government		*Other State Program (specify)	
Private Insurers		Other (specify)	
HMO/Managed Care		Unknown	
TOTAL CLIENTS			

*If RSA clients are from a State Program (Medicaid, Department of Aging, Department of Human Resources, etc), complete 10B.

10B. (If applicable.) Specific Maryland State Programs and contact information.

SPECIFIC MARYLAND STATE PROGRAM	NAME OF CONTACT PERSON	PHONE NUMBER/E-MAIL

21. ADDENDUM - STATEMENT OF READINESS FOR A RSA PROVISIONAL LICENSE

LEGAL AGENCY NAME

TRADING NAME (DBA)

I, _____, have the following items and policies in place:

1. An organizational chart that includes all positions with the name of the person in that position.
2. I have hired a RN who will be responsible for the oversight of the skilled nurses and aides. The job description, resume, and contract for this person must be submitted prior to receipt of the provisional license.
3. Policies and procedures as required by COMAR 10.07.05, RSA regulations.
4. A sample personnel file.
5. Sample patient files for adult and pediatric patients (if applicable).
6. Description of the Scope of Services to be provided by the agency, including services to be provided, geographic area of services, accepted referral sources, and accepted payer sources.

I, _____, have marketed and I am ready to admit 3 to 5 patients who require skilled care that will be provided by a certified nursing aide under the supervision of a registered nurse. If I am requesting a Level Three license, I am aware that I must have at least one client who has received a medical treatment or procedure ordered by a physician that can only be provided by a RN/LPN.

I, _____, understand that if for any reason I am unable to obtain 3 to 5 patients and/or do not demonstrate the ability to operate a RSA and do not follow all instructions in this letter, I may be denied initial licensure.

SIGNATURE OF APPLICANT

DATE