

## ADULT MEDICAL DAY CARE (AMDC) APPLICATION FOR LICENSURE

### 1. GENERAL INFORMATION

CHECK TYPE OF APPLICATION

<input type="checkbox"/> INITIAL	<input type="checkbox"/> CHANGE OF OWNERSHIP <input type="checkbox"/> CHANGE OF LOCATION	<input type="checkbox"/> NAME CHANGE <input type="checkbox"/> CHANGE IN CAPACITY
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LEGAL AGENCY NAME	TRADING NAME (DBA)
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E-MAIL ADDRESS	PHONE NUMBER	FAX NUMBER
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BUSINESS ADDRESS (physical location)	MAILING ADDRESS (if different)
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NUMBER, STREET	NUMBER, STREET
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CITY	STATE	ZIP	CITY	STATE	ZIP
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COUNTY	LICENSE NUMBER (if applicable)
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NAME OF DIRECTOR (Last, First, Middle Initial)	PHONE NUMBER	CELL NUMBER
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**REGISTERED NURSE ASSUMING OVERSIGHT RESPONSIBILITIES:**

NAME	LICENSE NUMBER	LICENSE EXPIRATION DATE
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**BUSINESS HOURS (in HH:MM format)**

	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
FROM:							
TO:							

**HOURS THAT STAFF ARE PRESENT (in HH:MM format)**

	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
FROM:							
TO:							

NUMBER OF PARTICIPANTS

AMDC IS:

Attached to a nursing home     A freestanding building

**INDICATE ALL HEALTH CARE SERVICES PROVIDED BY THE CENTER:**

SERVICES	SERVICE PROVIDED		
	BY STAFF	THROUGH CONTRACT	BY STAFF & THROUGH CONTRACT
PHYSICAL THERAPY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OCCUPATIONAL THERAPY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SPEECH PATHOLOGY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SOCIAL SERVICES AND COUNSELING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PHYSICIAN SERVICES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LIST OTHER SERVICES:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**2. OWNERSHIP (Type of business organization of disclosing entity)**

<input type="checkbox"/> SOLE PROPRIETORSHIP	<input type="checkbox"/> PARTNERSHIP	<input type="checkbox"/> NONPROFITS	CORPORATION
<input type="checkbox"/> ASSOCIATION	<input type="checkbox"/> GOVERNMENT UNIT	<input type="checkbox"/> MERGER	<input type="checkbox"/> LLP <input type="checkbox"/> LLC

NAME	ADDRESS
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IF PARTNERSHIP OR CORPORATION,  
PARTNER, OFFICER, DIRECTOR, OR STOCKHOLDER INFORMATION AND PERCENTAGE OWNED IF 25% OR MORE

NAME AND TITLE	E-MAIL	PHONE NUMBER	ADDRESS	% OWNED

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

**3. 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).

**4. 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 Maryland Department of Health. 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 the provisions of Health-General Article, Title 19, Subtitle 3, Annotated Code of Maryland and the administrative and procedural requirements pertaining to the Adult Medical Day Care Code of Maryland Regulations (COMAR 10.12.04).

I further certify that I will notify the OHCO 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 18 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.*

SIGNATURE OF APPLICANT	TITLE	DATE
SIGNATURE OF APPLICANT	TITLE	DATE

**FOR OFFICE USE ONLY**

DATE	REGISTRATION #	LICENSE #
COORDINATOR NAME		