STATE OF MARYLAND
MARYLAND DEPARTMENT OF HEALTH (MDH)
OFFICE OF HEALTH CARE QUALITY (OHCQ)

Form Approved 07/07/2015 (revised 5/.2019)
MDH Form AC.APP.1.0

AMBULATORY CARE

APPLICATION FOR LICENSURE

1. GENERAL INFORMATION

	AGENCY TYPE	CODE OF MARYLAND REGULATIONS (COMAR)
☐	Freestanding Ambulatory Surgery Center	10.05
☐	Freestanding Birthing Center	10.05
☐	Comprehensive Rehabilitation Facility	10.07.18
☐	Freestanding Kidney Dialysis Center	10.05
☐	Home Health Agency	10.07.10
☐	Hospice Care Agency	10.07.21
☐	Freestanding Major Medical Equipment Facility	10.05
☐	Cosmetic Surgery Centers	10.12.03

CHECK TYPE OF APPLICATION

☐ Initial ☐ 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)	FEIN NUMBER
NAME OF ADMINISTRATOR (Last, First, Middle Initial) ☐ Mr. ☐ Ms. ☐ Mrs.	AFTER HOURS/EMERGENCY CONTACT NUMBER	

BUSINESS HOURS (in HH:MM format)

	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
FROM:							
TO:							

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

☐ SOLE PROPRIETORSHIP ☐ PARTNERSHIP ☐ LLC ☐ CORPORATION

NAME	ADDRESS

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

NAME AND TITLE	ADDRESS	PERCENTAGE OWNED

NAME OF PRESIDENT (IF CORPORATION) OR MANAGER (IF LLC)		PHONE NUMBER	CELL NUMBER	
ADDRESS (number, street)		CITY	STATE	ZIP
IF CORPORATION, DATE OF ARTICLES OF INCORPORATION:	DATE OF INCORPORATION		IF LLC, DATE OF ARTICLES OF ORGANIZATION	

3. BACKGROUND

1. Has any owner, officer, director, agency, or managerial staff had a license revoked, suspended, or denied by the MDH within the last five years? ☐ No ☐ Yes (explain)

2. 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)

3. 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)

4. 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

4. WORKERS' COMPENSATION

Do you have any employees? ☐ Yes ☐ No

If you answered YES, attach a copy of your workers' compensation insurance policy and complete the following:

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).

5. FREESTANDING 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 ☐ Yes ☐ No	DAYS OR IS USED ☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday
NUMBER OF OPERATIING/PROCEDURE ROOMS	NAME OF MEDICAL DIRECTOR

ACCREDITED ☐ Yes ☐ No	ACCREDITING AGENCY	DATE OF ACCREDITATION
DEEMED STATUS ☐ Yes ☐ No	DEEMING AGENCY	DATE OF DEEMED STATUS

If you answered YES, attach a copy with this application

IDENTIFY ALL SPECIALTIES PROVIDED

☐ Cardiovascular
☐ Colon and Rectal
☐ Endoscopy
☐ GI Procedures
☐ General
☐ Lower GI Procedures
☐ Neurological
☐ OB/GYN
☐ Ophthalmology
☐ Oral
☐ Orthopedic
☐ Other GI Procedures
☐ Otolaryngology
☐ Pain Management
☐ Plastic Surgery
☐ Podiatric
☐ Thoracic
☐ Upper GI
☐ Urology
☐ Other (specify)

IDENTIFY ALL MAJOR MEDICAL EQUIPMENT UTILIZED IN THE AMBULATORY SURGERY CENTER

☐ Cardiac Catheterization Equipment Quantity: ☐
☐ Computer Tomography Equipment Quantity: ☐
☐ Radiation Therapy Equipment Quantity: ☐
☐ Magnetic Resonance Imager Quantity: ☐
☐ Lithotripter Quantity: ☐

6. FREESTANDING BIRTHING CENTER

NAME OF MEDICAL DIRECTOR	NAME OF DIRECTOR OF MIDWIFERY SERVICES

7. COMPREHENSIVE REHABILITATION FACILITY

DATE OF ACCREDITATION BY THE COMMISSION ON ACCREDITATION OF REHABILITATION FACILITIES	NAME OF MEDICAL DIRECTOR

CORE SERVICES PROVIDED

☐ Physical Therapy
☐ Physician
☐ Psychological
☐ Social

OTHER SERVICES PROVIDED

☐ Licensed Practical Nurse
☐ Occupational Therapy
☐ Orthotist
☐ Prosthetist
☐ Registered Nurse
☐ Rehabilitation Counselor
☐ Respiratory Therapist
☐ Speech Language Pathologist

8. COSMETIC SURGERY FACILITY

PLEASE CHECK THE BOX ONLY IF THE ANSWER TO THE QUESTION IS "YES".

☐ The applicant has been convicted of a crime of moral turpitude
☐ The applicant held a position as an owner, director, officer in a corporate entity that had its license revoked?
☐ Has an individual or corporate applicant consented to surrender a license as a result of a license revocation action?
☐ The corporate entity has an owner, director, officer, or other person with substantial interest whose conduct caused the revocation of a prior license?

ACCREDITED ☐ Yes ☐ No	ACCREDITING AGENCY	DATE OF ACCREDITATION
NAME OF MEDICAL DIRECTOR		NAME OF ADMINISTRATOR

9. FREESTANDING KIDNEY DIALYIS CENTER

DIALYSIS SERVICES PROVIDED

☐ HEMODIALYSIS
☐ PERITONEAL DIALYSIS
☐ TRANSPLANTATION
☐ HOME TRAINING - HEMODIALYSIS/PERITONEAL DIALYSIS
☐ HOME SUPPORT - HEMODIALYSIS/PERITONEAL DIALYSIS

IS REUSE PRACTICED ☐ Yes ☐ No	ISOLATION ROOM ☐ Yes ☐ No	BACK-UP GENERATOR ☐ Yes ☐ 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

NAME OF PARENT AGENCY	ADDRESS

ACCREDITED ☐ Yes ☐ No	ACCREDITING AGENCY	DATE OF ACCREDITATION
DEEMED STATUS ☐ Yes ☐ No	DEEMING AGENCY	DATE OF DEEMED STATUS

PATIENT POPULATION(S) SERVED

☐ Adult ☐ Maternal/Child Health	☐ Pediatric ☐ Psychiatric	☐ Other (list)

	SERVICE PROVIDED			
SERVICES	DIRECTLY	THROUGH CONTRACT	DIRECTLY & THROUGH CONTRACT	CONTRACTOR'S NAME
SKILLED NURSING	☐	☐	☐	
HOME HEALTH AIDES	☐	☐	☐	
PHYSICAL THERAPY	☐	☐	☐	
SPEECH LANGUAGE PATHOLOGY	☐	☐	☐	
OCCUPATIONAL THERAPY	☐	☐	☐	
MEDICAL SOCIAL SERVICES	☐	☐	☐	
INFUSION SERVICES	☐	☐	☐	
LIST OTHER SERVICES	☐	☐	☐	

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 ☐ Yes ☐ No	ACCREDITING AGENCY	DATE OF ACCREDITATION
DEEMED STATUS ☐ Yes ☐ No	DEEMING AGENCY	DATE OF DEEMED STATUS

NAME OF DIRECTOR	NAME OF MEDICAL DIRECTOR

12. 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 administrative and procedural requirements pertaining to the Code of Maryland Regulations (COMAR) checked below.

I further certify that I will notify the OHCQ 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:

☐ Ambulatory Surgery Center – COMAR 10.05
☐ Birthing Center – COMAR 10.05
☐ Comprehensive Outpatient Rehabilitation Facility – COMAR 10.07.18
☐ End Stage Renal Disease Provider – COMAR 10.05
☐ Home Health Agency – COMAR 10.07.10
☐ Hospice Agency – COMAR 10.07.21
☐ Major Medical Equipment Provider – COMAR 10.05
☐ Cosmetic Surgery Center – COMAR 10.12.03

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

13. ADDENDUM - BRANCH OFFICES

LICENSED NAME	LICENSE NUMBER

DOES THE AGENCY OPERATE ANY BRANCH OFFICES? ☐ No ☐ Yes (list all below)

STREET ADDRESS	CITY	STATE	ZIP	PHONE NUMBER
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