INSTRUCTIONS FOR COMPLETION OF RESIDENTIAL SERVICE AGENCY (RSA) LICENSURE APPLICATION

A Residential Service Agency (RSA) is a business that employs or contracts with individuals to provide at least one home health care service for compensation to an unrelated sick or disabled individual. This application is to receive a state license for a RSA from the Maryland Department of Health, Office of Health Care Quality (OHCQ). The RSA program is NOT a Medicare program. Current regulations for the RSA program can be found in Code of Maryland Regulations (COMAR) 10.07.05. For more information relating to RSAs visit the OHCQ Residential Service Agency Dashboard at

https://app.smartsheet.com/b/home?lx=WI2JkCnlI1Ng9CuRw1DP7ynUXphoZCJbZcV5Sw9DPzI

APPLICATION FOR INITIAL LICENSE PROCESS

To apply, first download the application onto your computer. You will be able to complete the application electronically or you can print it out and hand write the information into each appropriate section. Additional information for each required section can be found below.

REQUIRED SECTIONS

Please complete each section based on the following information:

Section 1 - General Information: Indicate what type of application (i.e. Initial, Upgrade in Services, etc.) Detail your agency's information including: The legal agency name, trading name (Doing Business As (DBA)), agency's email, phone number, fax number, agency's business address (for the physical location), mailing address (if different from the business address), agency's license number, agency's FEIN (Federal Employer Identification Number), agency administrator, agency after hours emergency contact information, and agency's business hours. Please note, for agencies with multiple locations provide the address and contact information for the agency's main office. Branch office location information will be collected in Section 7.

Section 2 - Ownership: Include information related to your agency's ownership: type of business organization of disclosing entity (sole proprietorship, partnership (including LLP), limited liability company (LLC), and corporation), name and address of ownership, the name, title, address and percentage of the agency owned by each owner, the agency's president (if Corporation) or manager's (if LLC) name, contact information, and address, and FEIN (Federal Employer Identification Number). If the ownership is a corporation, provide the date of Articles of Incorporation. If ownership is LLC provide the date of Articles of Organization.

Section 3 - Background: Respond "yes" or "no" to the background questions listed in Section 3 of the application. For Section 3, Questions 1 through 4 that you have answered "yes", provide a detailed explanation (including: dates, reasons for denials, suspensions, or revocation of the license, type of license, agencies, violations, or offenses). For Question 5, if you answered "no" please provided an explanation for this answer.

Section 4 – Worker's Compensation: First, identify if the agency has employees. If the agency has employees, provide the agency's worker's compensation insurance policy number, binder number, name of insurance company, policy's effective date, and the policy's expiration date. Additionally, attach a copy of the agency's worker's compensation insurance policy to the application (This can be added to the application electronically as an attachment). If your agency does not have workers' compensation insurance **AND** does not have any employees, submit a Letter of Exemption (sole proprietorships or partnerships) or Certificate of Compliance (corporations or LLCs) from the Certificate of Compliance Coordinator at the Workers' Compensation Commission. Additional information can be found under the Resource Links section of the OHCQ RSA Dashboard (see link above).

Section 5 – RSA Services: For this section if you are applying for a RSA Other License please complete question 5.A. only, skip question 5.B., and then proceed to question 5.C. If you are applying for a RSA License – Skilled Nursing and Aides Only please skip question 5.A., complete question 5.B., and then proceed to 5.C.

For all RSA Others, select all the home care services to be provided. The home care services include: Durable Medical Equipment (DME), Durable Medical Equipment with Oxygen, Therapy Services including speech therapy, occupational therapy, and physical therapy, Medical Social Services, Nutritional Services, Intravenous therapy, Skilled Nursing and Aides Only, or Ventilator Services.

If applying for a RSA License with "Skilled Nursing and Aides Only" service, please provide the level of home care services that your agency will be providing. The levels include: 1. Level One: RN supervision of Aides without medication management, 2. Level Two: RN supervision of Aides with medication management, or 3. 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.). Additional please provide the population to whom you will be providing these services. Next, list the types of complex care that will be provided by your agency. Finally, select if the agency is "for profit" or "not-profit". For all applicants that select Durable Medical Equipment (DME) in question 5.A., complete question 5.E. regarding information on accreditation.

Section 6 – Addendum – Branch Offices: "Branch office" means a satellite office of an RSA that is operated by the same person, corporation, or other business entity that manages the parent RSA, and has the same name of the parent RSA:

1. Ownership tax identification number as the parent business entity;
2. Upper-level management;
3. Policies and procedures; and
4. Provides services within the same geographic area served by the parent business entity.

Provide your agency's licensed name and license number. Select "yes" if your agency operates any branch offices. Select "no" if your agency does not operate any branch offices. If you answered "yes", provide the address and phone number for each of the agency's branch offices.

Section 7 - Affidavit: If the program is going to be in more than one applicant's name, each applicant's signature is required. Provide the signature of each applicant, his/her title, and the date the application was signed by that applicant. This signator agrees under the penalties of perjury that the information given in this application is true. This applicant's signature also certifies that your agency follows the administrative and procedural requirements pertaining to the Code of Maryland Regulations (COMAR) 10.07.05. Additionally, you are accepting responsibility to notify OHCQ if there are any future substantive changes in the agency and operation, and that written notice will be given before the effective date of the change. The signators also swear and affirm that each applicant is over the age of 21, is fully competent, and understands the terms of this application.

REQUIRED DOCUMENTATION

In addition to a completed application, additional supporting documents are required to finalize your application. See below for a list of additional documents that are required for each RSA licensure type.

1. An organizational chart that includes all positions with the name of the person in that position.
2. Policies and procedures as required by COMAR 10.07.05.
3. A business plan as required by COMAR 10.07.05.
4. A sample personnel file.
5. Sample patient files for adult and pediatric patients (if applicable).

Suggested Format for Writing Policy and Procedure Statements: When developing your agency's policies and procedures, the following elements are recommended:

1. Date of approval by governing body.
2. Title or subject of the policy. (Example: Employee Orientation)
3. Policy statement. Describe the agency's policy on the subject. (Example: All employees shall receive orientation prior to assuming responsibilities for the position.)
4. Purpose of the policy. Describe why the subject is important. (Example: To assure staff understand and comply with all agency policies and procedures.)
5. Procedures. Define who, when, and where. (Example: Who will be responsible? What materials will be used? How will participation in orientation be documented?)

Suggested Format for Writing Job Descriptions: When developing your agency's job descriptions, the following elements are recommended:

1. Date of approval by governing body.
2. Position title. (Example: Nursing Supervisor)
3. Position to which this job title reports. (Example: Reports to Director of Nursing)
4. Qualifications. Educational and experience requirements. (Example: Graduation from accredited school of nursing. Number of years of home health experience. Number of years of supervisory experience.)
5. Credential requirements. (Example: Current license in the State of Maryland) Job responsibilities. List the tasks that the person in this position would have to perform. (Example: Perform annual performance evaluations on all licensed nurses and home health aides. Participate in quality assurance activities.)

APPLICATION FINALIZATION

Electric Submission: To submit the completed application and all supporting documentation electronically to OHCQ, visit the OHCQ RSA Dashboard and click on the RSA Licensure Application Form – RSA or RSA Licensure Application Form – RSA Others (https://app.smartsheet.com/b/form/26fb6697dcc841b7ae8fde911eec9b05). Complete the form with the following information: Name of RSA, type of RSA, contact information for the agency's contact person including: Name, Position, email address, phone number, and secondary phone number. Next, upload the following documents to the form:

1. Completed application
2. Organizational chart
3. Policies and procedures
4. Sample personnel file
5. Sample patient file for adult and pediatric patients
6. Business Plan - Scope of services
7. Worker's compensation documentation

Finally, select the "Attestation" box confirming that all the information in the application and supporting documents are correct and true. If you would like to have a copy of the form and attachments sent to your email, please select the "Send me a copy of my responses". It is recommended that you keep a copy of your responses and documents for your own records. Once your application is submitted you will receive email updates regarding your pending application.

Paper Submission: To submit a hard copy of the application and supporting documents please return in person or via mail to the following address: Ambulatory Care Program, Office of Health Care Quality, 7120 Samuel Morse Drive, Second Floor, MD 21046

LICENSE NOTIFICATION

All application notifications and process updates will be made by email. If no email is provided there may be an additional delay in processing your application.

Once your application has been approved, a formal approval or denial letter will be mailed to your agency from OHCQ through the mail. If your agency is approved, an operating license will be sent to your agency with effective date.

ADDITIONAL INFORMATION

To add services to your RSA you must submit a new application to the OHCQ for review and approval with required updates to the policies and procedures.

If you do not intend to continue with your license, you must return your operating license to OHCQ.

An unannounced on-site survey of your facility may be performed at any time to determine compliance with RSA requirements. Visit the OHCQ RSA Dashboard for additional information regarding survey activities and procedures.

If you are operating an unlicensed RSA program, your Medicaid provider number and reimbursement are in jeopardy of termination.

RSA HOTLINE

Current regulations for the RSA program can be found in Code of Maryland Regulations (COMAR) 10.07.05. Regulations can be searched online at http://www.dsd.state.md.us/. In accordance with State regulations, the State of Maryland has established a RSA Hotline. The purpose of the Hotline is:

- To receive complaints about local RSAs; To receive questions about local RSAs; and
- To lodge complaints concerning the implementation of advance directives.

The Hotline number is 800-492-6005. Voice messages can be left on the Hotline number. Written complaints may be submitted to the address at the end of the instructions or via the OHCQ RSA Dashboard at

https://app.smartsheet.com/b/home?lx=WI2JkCnlI1Ng9CuRw1DP7ynUXphoZCJbZcV5Sw9 DPzI

QUESTIONS

Please visit the OHCQ RSA Dashboard (https://app.smartsheet.com/b/home?lx=WI2JkCnlI1Ng9CuRw1DP7ynUXphoZCJbZcV5Sw9DPzI) or contact 410-402-8267 or additional information and questions related to this application.

RESIDENTIAL SERVICES AGENCY (RSA) APPLICATION FOR LICENSURE

1. GENERAL INFORMATION

TYPE OF APPLICATION

○ INITIAL ○ UPGRADE ○ OTHER: _____

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) Ms./Mrs./Mr. (Circle One)			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:	FEIN	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 Maryland Department of Health (MDH) within the last five years? ◯ No ◯ Yes
(explain: please provide denial/revocation/suspension reason and date of denial/revocation/suspension)

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. 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 (explain)

4. Does the owner, applicant, manager, alternate manager, managerial staff, or any other staff member have a criminal of conviction or any other criminal history? ◯ No ◯ Yes (explain)

5. 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. ◯ No (explain) ◯ 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. RSA SERVICES

If you are applying for a RSA Other License please answer section 5.A. only and then proceed to question 5.C. If you are applying for RSA - Skilled Nursing & Aides Only License, please skip 5.A. and answer 5.B only before proceeding to question 5.C. Only applicants applying for a RSA Other: Durable Medical Equipment (DME) should complete question 5.E.

5.A. *RSA OTHERS*: HOME CARE SERVICES TO BE PROVIDED (check all that apply)

☐ Durable Medical Equipment*	☐ Medical Social Services	☐ Skilled Nursing
☐ Durable Medical Equipment w/ Oxygen	☐ Occupational Therapy	☐ Speech Therapy
☐ Intravenous or Related Therapies	☐ Physical Therapy	☐ Ventilator Services

5.B. *RSA - Skilled Nursing and Aides Only* – HOME CARE SERVICES TO BE PROVIDED (check only one level of care) *If you have selected Skilled Nursing & Aides Only please indicate what level of home care services will be provided (check only one level)

◯ 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.)

5.B.1. POPULATION – Please select the population to whom you intend to provide services: ◯ Adults ◯ Pediatrics ◯ Both

5.C. LIST THE TYPE(S) OF COMPLEX CARE TO BE PROVIDED BY YOUR AGENCY:

5.D. CATEGORY
◯ For Profit ◯ Non-Profit

5.E. (*DME ONLY)* – If DME, ACCREDITED ◯ Yes ◯ No	If DME, ACCREDITED AGENCY	If DME, DATE OF ACCREDITATION

○ 6. 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
		MD		
		MD		
		MD		
		MD		
		MD		
		MD		
		MD		

7. 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 MDH. 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) 10.07.05.

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.

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