STATE OF MARYLAND

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

# ASSISTED LIVING

Form Approved 4/4/13 DHMH Form AL.APP.1.1

# APPLICATION FOR LICENSURE

**1. GENERAL INFORMATION**

CHECK TYPE OF APPLICATION

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Initial | | | Change of Ownership   (specify effective date) | | Other Change (specify type) | | |
| LICENSE NUMBER (if applicable) | | | | WEBSITE (if applicable) | | | |
| 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 |

Does the owner, corporation, or partnership operate and manage the assisted living program? Yes No (identify the management structure and its relationship to the business owner)

|  |  |
| --- | --- |
| NUMBER OF BEDS REQUESTED | LEVEL OF CARE REQUESTED  1 2 3 |

Are all areas of the assisted living facility fully constructed? Yes No (identify any areas not fully constructed and the extent of construction progress)

|  |  |  |  |
| --- | --- | --- | --- |
| NAME OF MANAGER | PHONE NUMBER | CELL NUMBER | |
| HOME ADDRESS (number, street) | CITY | STATE | ZIP |
| NAME OF ALTERNATE MANAGER | PHONE NUMBER | CELL NUMBER | |
| HOME ADDRESS (number, street) | CITY | STATE | ZIP |
| NAME OF DELEGATING NURSE (DN) | PHONE NUMBER | CELL NUMBER | |
| HOME ADDRESS (number, street) | CITY | STATE | ZIP |
| DN’S LICENSE NUMBER | EXPIRATION DATE OF DN’S LICENSE | | |

Is your facility planning to operate, or currently operating, an “Alzheimer’s Special Care Unit or Program?”  
No Yes (refer to the instruction guide for details on submitting your program description)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **3. OWNERSHIP** (Type of business organization of disclosing entity) | | | | | | | |
| SOLE PROPRIETORSHIP | | PARTNERSHIP | | | | CORPORATION | |
| NAME | | | ADDRESS | | | | |
| 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 | | |
| NAME OF PRESIDENT | | PHONE NUMBER | | CELL NUMBER | |
| ADDRESS (number, street) | | CITY | | STATE | ZIP |
| **4. BACKGROUND** | | | | | |

1. Has the applicant, owner, or managerial staff ever had a license, permit, or certificate to provide care to third parties that has been denied, suspended, or revoked? No Yes (explain)
2. Does the applicant currently hold, or has the applicant previously held, any license or certification for the operation

of a health care facility or similar health care program? No Yes (explain)

1. Does the owner, applicant, manager, alternate manager, other staff, or any household member have a criminal

conviction or other criminal history? No Yes (explain)

**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. 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.

I certify that this agency is in compliance with administrative and procedural requirements pertaining to the Assisted Living Programs Code of Maryland Regulations (COMAR 10.07.14).

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 |
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