DEVELOPMENTAL DISABILITIES ADMINISTRATION
APPLICATION FOR LICENSURE

1. GENERAL INFORMATION

Type of Application: ☐ Initial ☐ Renewal ☐ Other Changes (specify)

CHECK TYPE(S) OF LICENSE(S) REQUESTED (check all that apply)

	RESIDENTIAL	CODE OF MARYLAND REGULATIONS (COMAR)
☐	Alternative Living Unit	10.22.08
☐	Community Supported Living Arrangements	10.22.08
☐	Group Home	10.22.08
☐	Individual Family Care	10.22.08
☐	Innovative Program Service Plan	10.22.02.09F
☐	Program for Children with Developmental Disabilities	14.31.05-07
☐	Program for Medically Fragile Children	14.31.05-07
	NON-RESIDENTIAL	COMAR
☐	Community Learning Services	10.22.07
☐	Day Habilitation	10.22.07
☐	Employment Discovery & Customization	10.22.07
☐	Family & Individual Support Services	10.22.06
☐	Resource Coordination	10.22.09
☐	Supported Employment	10.22.07
☐	Vocational Services	10.22.07
☐	Other (specify):	

IF INITIAL APPLICATION: DATE INTEREST MEETING ATTENDED	APPLICANT ID #
LEGAL AGENCY NAME	TRADING NAME (DBA)
BUSINESS ADDRESS (physical location): NUMBER, STREET	MAILING ADDRESS (if different): NUMBER, STREET
CITY / STATE / ZIP	CITY / STATE / ZIP
COUNTY	PROVIDER NUMBER (if applicable)
NAME OF EXECUTIVE DIRECTOR (Last, First, Middle Initial)	EMPLOYER ID NUMBER (EIN)
E-MAIL ADDRESS	PHONE NUMBER / FAX NUMBER

INDIVIDUAL TO CONTACT REGARDING THIS APPLICATION (if different from Executive Director): NAME	TITLE
NUMBER, STREET	CITY / STATE / ZIP
E-MAIL ADDRESS	PHONE NUMBER / FAX NUMBER

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

PRINCIPAL INCORPORATED NAME	RESIDENT AGENT
TYPE OF CORPORATION	INCORPORATION DATE

☐ FOR PROFIT ☐ NON-PROFIT	AGENCY REGISTERED AS A MBE (Minority Business Enterprise)? ☐ No ☐ Yes

TYPE OF BUSINESS ORGANIZATION:
☐ SOLE PROPRIETORSHIP ☐ PARTNERSHIP ☐ CORPORATION

3. APPLICANT BACKGROUND

A. Has any action been taken by State/federal/local government against the applicant, any members of the Board, or of senior management, disciplining them, excluding them, or affecting in any way their participation in a State/federal/local government program - for example, Medicaid or Medicare? ☐ No ☐ Yes (please explain)

B. Does the parent company, owner, agent, officer, or managerial staff own or operate a health care facility/agency licensed or surveyed by the Office of Health Care Quality? ☐ No ☐ Yes (please explain)

C. 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 (please explain)

D. 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

E. Has the applicant, board member, or top management been affiliated with any program providing health care which has been disciplined by excluding them or affecting in any way the continued provision of services?
☐ No ☐ Yes (please explain)

F. Does the applicant serve individuals diagnosed with developmental disabilities in another state?
Currently? ☐ No ☐ Yes
In the past five years? ☐ No ☐ Yes

G. Is the applicant funded by another state/entity to serve individuals diagnosed with developmental disabilities?
Currently? ☐ No ☐ Yes
In the past five years? ☐ No ☐ Yes

H. *(Initial applicants only)* Has the applicant ever been associated with an agency licensed by the DDA in Maryland to provide services to individuals with developmental disabilities? ☐ No ☐ Yes

I. If an answer to question F, G, or H above is yes, provide the following details as an attachment with a reference to the specific question answered.

NAME OF AGENCY	CONTACT PERSON		
NUMBER, STREET	CITY	STATE	ZIP
E-MAIL ADDRESS	PHONE NUMBER	FAX NUMBER	
DATES AND LENGTH OF TIME SERVICES WERE PROVIDED	TYPES OF SERVICES PROVIDED		
LOCATIONS	STATE AGENCY THAT LICENSES OR REGULATES THIS ACTIVITY		

CONTACT PEOPLE

ANY ADDITIONAL DETAILS

4. WORKERS' COMPENSATION & UNEMPLOYMENT INSURANCE

Do you have any employees? ☐ Yes ☐ No If yes – How many employees?

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).

Do you have unemployment insurance? ☐ Yes ☐ No

5. QUALITY ASSURANCE (QA) PLAN

DATE OF INITIAL OR MOST RECENT QA PLAN SUBMISSION	DATE OF MOST RECENT QA PLAN APPROVAL (as applicable)

IF THE APPROVAL DATE IS GREATER THAN ONE YEAR AGO:

REASON FOR THE DELAY	PLAN FOR SUBMITTING QA PLAN & ANNUAL REPORT FOR APPROVAL

6. LICENSED SITE LOCATIONS

NUMBER OF LICENSED SITE PROPOSED OR LICENSED LOCATIONS	IS A LIST OF ALL THE LICENSED SITE LOCATIONS ATTACHED TO THIS APPLICATION? ☐ Yes ☐ No

Attach the "List of Licensed Site Locations" form available on the OHCQ website at http://dhmh.maryland.gov/ohcq

7. EQUAL OPPORTUNITY (VOLUNTARY) (CONSIDER MOVING TO END OF APPLICATION)

To further its commitment to equal opportunity, the State of Maryland requests licensees provide the following voluntary information. This information will be used for statistical purposes only by authorized personnel.

1. Is the (applicant) agency certified through the Maryland Department of Transportation (MDOT) as a Minority Business Enterprise (MBE) or Disadvantaged Business Enterprise (DBE)? ☐ No ☐ Yes
2. Is the (applicant) agency a minority owned or operated business (at least 51% owned/operated)? ☐ No ☐ Yes (please complete the following chart)

NAME OF GOVERNING BODY MEMBER OR OFFICER OF THE CORPORATION	MINORITY?	MINORITY CLASSIFICATION (AFRICAN AMERICAN; HISPANIC; NATIVE AMERICAN; ALASKAN NATIVE; ASIAN AMERICAN; FEMALE)	DATE ELECTED OR APPOINTED TO POSITION
	☐ Yes ☐ No		
	☐ Yes ☐ No		
	☐ Yes ☐ No		
	☐ Yes ☐ No		
	☐ Yes ☐ No		
	☐ Yes ☐ No		
	☐ Yes ☐ No		
	☐ Yes ☐ No		

8. BOARD OF DIRECTORS MEMBER INFORMATION (Please submit an attachment for any additional members)

BOARD MEMBER #1 - MEMBER TYPE: ☐ VOTING ☐ STAFF ☐ COMMUNITY

FIRST NAME, MIDDLE INITIAL	LAST NAME	BOARD POSITION		DATE TERM STARTS	DATE TERM ENDS
ADDRESS (NUMBER, STREET)	CITY	STATE	ZIP	PHONE NUMBER	

EMAIL ADDRESS:

BOARD MEMBER #2 - MEMBER TYPE: ☐ VOTING ☐ STAFF ☐ COMMUNITY

FIRST NAME, MIDDLE INITIAL	LAST NAME	BOARD POSITION		DATE TERM STARTS	DATE TERM ENDS
ADDRESS (NUMBER, STREET)	CITY	STATE	ZIP	PHONE NUMBER	

EMAIL ADDRESS:

BOARD MEMBER #3 - MEMBER TYPE: ☐ VOTING ☐ STAFF ☐ COMMUNITY

FIRST NAME, MIDDLE INITIAL	LAST NAME	BOARD POSITION		DATE TERM STARTS	DATE TERM ENDS
ADDRESS (NUMBER, STREET)	CITY	STATE	ZIP	PHONE NUMBER	

EMAIL ADDRESS:

BOARD MEMBER #4 - MEMBER TYPE: ☐ VOTING ☐ STAFF ☐ COMMUNITY

FIRST NAME, MIDDLE INITIAL	LAST NAME	BOARD POSITION		DATE TERM STARTS	DATE TERM ENDS
ADDRESS (NUMBER, STREET)	CITY	STATE	ZIP	PHONE NUMBER	

EMAIL ADDRESS:

BOARD MEMBER #5 - MEMBER TYPE: ☐ VOTING ☐ STAFF ☐ COMMUNITY				DATE TERM	
FIRST NAME, MIDDLE INITIAL	LAST NAME	BOARD POSITION		STARTS	ENDS
ADDRESS (NUMBER, STREET)	CITY	STATE	ZIP	PHONE NUMBER	

EMAIL ADDRESS:

BOARD MEMBER #6 - MEMBER TYPE: ☐ VOTING ☐ STAFF ☐ COMMUNITY				DATE TERM	
FIRST NAME, MIDDLE INITIAL	LAST NAME	BOARD POSITION		STARTS	ENDS
ADDRESS (NUMBER, STREET)	CITY	STATE	ZIP	PHONE NUMBER	

EMAIL ADDRESS:

BOARD MEMBER #7 - MEMBER TYPE: ☐ VOTING ☐ STAFF ☐ COMMUNITY				DATE TERM	
FIRST NAME, MIDDLE INITIAL	LAST NAME	BOARD POSITION		STARTS	ENDS
ADDRESS (NUMBER, STREET)	CITY	STATE	ZIP	PHONE NUMBER	

EMAIL ADDRESS:

BOARD MEMBER #8 - MEMBER TYPE: ☐ VOTING ☐ STAFF ☐ COMMUNITY				DATE TERM	
FIRST NAME, MIDDLE INITIAL	LAST NAME	BOARD POSITION		STARTS	ENDS
ADDRESS (NUMBER, STREET)	CITY	STATE	ZIP	PHONE NUMBER	

EMAIL ADDRESS:

9. BOARD OF DIRECTORS REPRESENTATION (For Developmental Disabilities Services COMAR 10.22)

1. Identify at least 1 board member who has a developmental disability.

2. Identify at least 1 board member who is the family member of an individual with a developmental disability.

3. Identify at least 1 board member who has experience in the field of developmental disabilities.

4. Are at least 75% of the board members residents of the State of Maryland, or do at least 75% of the board members reside within a 100 mile radius of the administrative office which is located in Maryland?
   ☐ Yes ☐ No (explain)

5. Are any voting board members employees of the licensee or immediate family members of an employee of the licensee? ☐ No ☐ Yes If yes, provide the board member(s) name:
   If yes, is the board member an employee who receives services from the licensee? ☐ Yes ☐ No

6. Do any board members own property that is leased back to the licensee? ☐ No ☐ Yes (if yes provide board member name and property address)

7. Do all board members have an understanding of the responsibilities of the governing body as delineated in the regulations? ☐ Yes ☐ No

8. If out-of-state board of directors, which board member(s) are members of the Maryland required advisory board?

10. BOARD OF DIRECTORS REPRESENTATION (FOR OFFICE OF CHILDREN SERVICES ONLY COMAR 14.31)

1. Identify at least 5 board members who have an interest in or knowledge of the needs of children and their families.

2. Identify at least 1 board member who has demonstrated experience or knowledge in the human services field.

3. Identify at least 1 board member who has demonstrated knowledge in the field of accounting, business, or financial management.

4. Identify at least 1 board member who is a resident of the State of Maryland.

5. Has any board member or advisory board member been convicted of, or entered a plea of guilty or nolo contendere, to a charge of child abuse or neglect or contributing to the delinquency of a minor? ☐ No ☐ Yes
   If yes, provide details

6. Are any board members employees of the licensee or immediate family members of an employee of the licensee? ☐ No ☐ Yes If yes, provide the board member(s) name:

7. Are any board members related to the Program Administrator? ☐ No ☐ Yes
   If yes, provide details

8. Are any board members compensated for providing goods or services to the licensee? ☐ No ☐ Yes
   If yes, provide details

9. Have all board members received training in the responsibilities regarding the governance of the licensee? ☐ Yes ☐ No

10. Has each board member read the regulations and understood that s/he may be requested to meet with authorized staff of the licensing agency? ☐ Yes ☐ No

11. Has a completed criminal background check been received on each board member? ☐ Yes ☐ No

12. Has a completed Child Protective Services check been received on each board member? ☐ Yes ☐ No

13. If out-of-state board of directors, which board member(s) are members of the Maryland required advisory board?

14. Do any board members own property that is leased back to the licensee? ☐ No ☐ Yes (provide details for attaining compliance with COMAR 10.22.02.08)

IF CHILDREN'S LICENSEE NAME OF CHIEF FINANCIAL OFFICER	E-MAIL ADDRESS

11. BOARD OF DIRECTORS SIGNATURES

1. Has this corporation had a license revoked by a licensing agency in the past 10 years? ☐ No ☐ Yes

2. Has any corporate officer of this Board served as a corporate officer of a corporation or entity that has had a license revoked by a licensing agency in the past 10 years? ☐ No ☐ Yes If yes, provide details

3. If this Board does not meet the requirements of 10.22.02.08C(7), has an Administration approved community-based advisory board been established? ☐ No ☐ Yes (submit DDA approval of alternative board)

As the Executive Director/Program Administrator of the Organization, I hereby affirm that this Board has defined and prohibited those circumstances which would create a personal or financial conflict for members of the governing body/board of directors, corporate officers, staff/employees, care providers, agents, assigns, volunteers, and members of the standing committee.

As the Executive Director/Program Administrator of the Organization, I hereby affirm that the information recorded on this document contains no misrepresentations or falsifications and that this information given by me is true and complete to the best of my knowledge and belief. I am aware that should an investigation at any time disclose any representation or falsification, the Department, at their discretion, may pursue administrative actions to the extent of non-renewal or revocation of the organization's license to support individuals with developmental disabilities in the State of Maryland.

SIGNATURE OF EXECUTIVE DIRECTOR/PROGRAM ADMINISTRATOR	PRINT NAME	DATE

12. STAFF CRIMINAL HISTORY

COMPLETE FOR ALL CURRENT EMPLOYEES. USAGE OF ANOTHER FORMAT IS ACCEPTABLE, PROVIDED ALL REQUESTED INFORMATION IS INCLUDED.

EMPLOYEE NAME	DATE OF HIRE	DATE OF HIRE	TYPE OF BACKGROUND CHECK REQUESTED (CHRC OR CBC)	STATUS OF BACKGROUND CHECK REQUEST		DATE OF MOST RECENT FEDERAL & STATE LEIE CHECK	YOUTH PROGRAMS ONLY: DATE OF CJIS FINGERPRINTING and CHILD PROTECTIVE SERVICES CHECK
Example: John Doe	1-4-1998	1-2-1998	☐ CHRC ☒ CBC	Completed 1-4-1998		7-1-2011	7-1-2011; 7-1-2011
			☐ CHRC ☐ CBC				
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I hereby certify that:
1. A CHRC or CBC has been completed on all staff & any criminal history has been discussed to the satisfaction of the agency;
2. No staff employed or contracted by the agency appear on the LEIE listing;
3. The above information is true and correct as of: date; and
4. (Youth programs only) Fingerprinting has been completed for all staff and all staff are in compliance with COMAR 14.31.06.05A(4)(a)-(e).

PERSON COMPLETING THE FORM SIGNATURE	PRINT NAME	DATE
EXECUTIVE DIRECTOR SIGNATURE	PRINT NAME	DATE

13. STAFF TRAINING - Developmental Disabilities Services (COMAR 10.22.02.11C&D)

Please review the training record of each staff. For each training successfully completed, document the staff name in the 1st column and enter the date of training(s) successfully completed (Attach additional pages if needed, or utilize your own spreadsheet format.)

STAFF NAME	REQUIRED TRAININGS										
	INITIAL BLOODBORNE PATHOGENS	ANNUAL UPDATE BLOODBORNE PATHOGENS	CPR	FIRST AID	COMMUNITY INTEGRATION	IDOOPI	CHARACTERISTICS	FUNDAMENTAL RIGHTS	COMMUNICABLE DISEASES	SUPPORTING IND & FAMILIES - CHOICE MAKING	COMMUNICATION

Licensed providers are held accountable to COMAR regulations associated with the staff training. Staff must meet all required training prior to providing services independently to participants. Staff training and qualification must be initially and continually met for payments.

EXPLAIN ALL INCOMPLETE TRAINING ITEMS ABOVE, INCLUDING THE PLAN FOR BRINGING STAFF INTO COMPLIANCE WITH DDA-MANDATED TRAINING REQUIREMENTS.

I hereby certify that the above information is true and correct as of: date

PERSON COMPLETING THE FORM SIGNATURE	PRINT NAME	DATE
EXECUTIVE DIRECTOR SIGNATURE	PRINT NAME	DATE

14. STAFF TRAINING - Office of Children Services (COMAR 14.31.06.05F(3))

Please review the training record of each staff. For each training successfully completed, document the staff name in the 1st column and enter the date of training(s) successfully completed. Attach additional pages if needed, or utilize your own spreadsheet format.)

STAFF NAME	REQUIRED TRAININGS															
	REQUIRED TRAININGS:	EMERGENCY PREPAREDNESS & GENERAL SAFETY	CPR	FIRST AID	CHILD ABUSE & NEGLECT	SUICIDE RISK	DISCIPLINE & BEHAVIOR MANAGMENT	MEDICATION MANAGEMENT	INFECTION CONTROL	PARENTING ISSUES	PSYCHOSOCIAL & EMOTIONAL NEEDS	SPECIAL NEEDS OF THE POPULATION	CHILD DEVELOPMENT	ROLE OF CHILD CARE EMPLOYEES	FOOD PREP, SERVICE, & NUTRITION	COMMUNICATION

Licensed providers are held accountable to COMAR regulations associated with the staff training. Staff must meet all required training prior to providing services independently to participants. Staff training and qualification must be initially and continually met for payments.

EXPLAIN ALL INCOMPLETE TRAINING ITEMS ABOVE, INCLUDING THE PLAN FOR BRINGING STAFF INTO COMPLIANCE WITH DDA-MANDATED TRAINING REQUIREMENTS.

I hereby certify that the above information is true and correct as of: date

PERSON COMPLETING THE FORM SIGNATURE	PRINT NAME	DATE
EXECUTIVE DIRECTOR SIGNATURE	PRINT NAME	DATE

15. POLICIES AND PROCEDURES

In conformance with applicable Code of Maryland Regulations (10.22.02.10), check the appropriate box for each policy and procedure demonstrated in the attached policies and procedures document:

Policy and Procedure	Present			Modified since last OHCQ survey
	Yes	No	N/A	
COMAR 10.22.02.10				
A(1): Each individual's health and safety needs, as identified in the IP, are being met	☐	☐	☐	☐
A(2): Individuals' fundamental rights are ensured, in accordance with Health-General Article, §7-1002, Annotated Code of Maryland	☐	☐	☐	☐
A(3): Services provided in a manner that promotes individual choice and the exercise of individual rights	☐	☐	☐	☐
A(4): Confidentiality for each individual as per Health-General Article, §7-1010, Annotated Code of Maryland	☐	☐	☐	☐
A(5): Implementation of a grievance process	☐	☐	☐	☐
A(6): Services are provided without discrimination	☐	☐	☐	☐
A(7): All incidents are reported and investigated in accordance with DDA's Policy on Reportable Incidents and Investigations (PORI, revised 10/1/2007)	☐	☐	☐	☐
A(8): Medications administered in accordance with MATP	☐	☐	☐	☐
A(9): Compliance with COMAR 10.27.11 (Nursing delegation)	☐	☐	☐	☐
A(10): Any individual whose behaviors require intervention receive the safeguards required by regulation	☐	☐	☐	☐
A(11)(a): In order for an individual to be required to pay for property damage caused by his/her actions, the IP shows evidence that the individual has a history of destructive behaviors that have been documented in the behavior plan (BP)	☐	☐	☐	☐
A(11)(b): In order for an individual to be required to pay for property damage caused by his/her actions, the IP shows evidence that the individual has a BP that addresses the destructive behavior	☐	☐	☐	☐
A(11)(c): In order for an individual to be required to pay for property damage caused by his/her actions, the IP shows evidence that the individual has the ability to pay for damages	☐	☐	☐	☐
A(11)(d): In order for an individual to be required to pay for property damage caused by his/her actions, the IP shows evidence that the licensee's standing committee has reviewed and approved the damage payment	☐	☐	☐	☐
A(11)(e): In order for an individual to be required to pay for property damage caused by his/her actions, the IP shows evidence that the licensee has reported the approval to the Regional Director	☐	☐	☐	☐
A(12): Compliance with H-G Article §5-605, Annotated Code of Maryland: Surrogate Decision Making	☐	☐	☐	☐
A(13): No financial or personal conflict of interest - members of governing body, staff, care providers, volunteers, standing committee	☐	☐	☐	☐
A(14): Fiscal affairs of Licensee conducted in accordance with generally accepted accounting practices	☐	☐	☐	☐
A(15)(a): Adequate protection for finances and property of individuals, including a system to ensure funds are used appropriately for the individual's needs and preferences	☐	☐	☐	☐
A(15)(b): Adequate protection for finances and property of individuals, including a system to keep personal funds separate from Licensee funds and the timely transfer of funds when an individual leaves	☐	☐	☐	☐
A(15)(c): Adequate protection for finances and property of individuals, including an individual's timely access to funds	☐	☐	☐	☐
A(15)(d): Adequate protection for finances and property of individuals, including an accounting of the individual's funds, on request	☐	☐	☐	☐
A(15)(e): Adequate protection for finances and property of individuals, including accrual of interest, if interest bearing account	☐	☐	☐	☐
A(16): State/Federal safety precautions, infection control and standard precautions implemented	☐	☐	☐	☐
A(17): Disaster/emergency plans in place with adequate drills	☐	☐	☐	☐
A(18): Individuals do not perform duties of paid staff	☐	☐	☐	☐
A(19): Individual only performs household duties as shared by the household, as activity documented in IP, or remunerated as part of a training program	☐	☐	☐	☐

16. POLICIES AND PROCEDURES (Continued)				
B(1): Residential service providers operating ALUs and/or GHs develop an emergency plan for all types of emergencies that includes: procedures to be followed before, during and after for (a) through (g)	☐	☐	☐	☐
B(2): Residential service providers operating ALUs and/or GHs develop an emergency plan for all types of emergencies that includes: notifications to families, staff, DDA	☐	☐	☐	☐
B(3): Residential service providers operating ALUs and/or GHs develop an emergency plan for all types of emergencies that includes: staff coverage, organization, and assignment of responsibilities including (a) through (c)	☐	☐	☐	☐
B(4): Residential service providers operating ALUs and/or GHs develop an emergency plan for all types of emergencies that includes: continuity of operations	☐	☐	☐	☐
B(5): Residential service providers operating ALUs and/or GHs develop an emergency plan for all types of emergencies that includes: procedures for back-up records (a) and (b)	☐	☐	☐	☐
B(6): Residential service providers operating ALUs and/or GHs develop an emergency plan for all types of emergencies that includes: provisions to share plans with local emergency management organizations	☐	☐	☐	☐
B(7): Residential service providers operating ALUs and/or GHs develop an emergency plan for all types of emergencies that includes: executive summary of procedure provided to family member upon request	☐	☐	☐	☐
C: Ensure that all staff, care providers, consultants and volunteers are aware of policies and implement each policy as adopted	☐	☐	☐	☐
D: Provide sufficient information about the grievance process to individuals served, and/or their proponents, to enable individual to effectively use process	☐	☐	☐	☐
Nursing:				
Medication P&P: Obtaining orders and medications (MTTP 1:4-9; 2:2-7; 2:4-2; 2:4-7; 2:3-18; 2:3-26)	☐	☐	☐	☐
Medication P&P: Administration and storage (MTTP 1:1-18; 1:4-9; 2:2-7; 2:3; 2:3-26; 2:2-28; 2:4-2; 2:4-7)	☐	☐	☐	☐
Medication P&P: Controlled drugs (MTTP 1:4-9; 2:1-9; 2:2-5; 2:2-7)	☐	☐	☐	☐
Medication P&P: Errors (10.27.11; MTTP referenced 2:3-17; 2:4-10)	☐	☐	☐	☐
Medication P&P: Determining ability to self-medicate (MTTP Chapter 8)	☐	☐	☐	☐
Procedures re: Reporting/Communication of information (MTTP 1:2-7; 1:3-4; 1:3-7; 1:3-10 & 11; 1:4-9; 3:2-9)	☐	☐	☐	☐
The RN Role (10.27.11; MTTP 6-5)	☐	☐	☐	☐
Please explain all items checked "no" above, including the plan for bringing agency into compliance with DDA-required policy requirements:				

17. AFFIDAVIT

I hereby certify that the information contained on this application form and supporting documents are true and correct.
I affirm under the penalty of perjury, as per COMAR 10.22.02.02A(2) and (3) and 10.22.02.08C(1), (2), (3), and (6), that this application and all the attachments have been developed and approved by the governing body of this Corporation legally known as: .
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 and/or the revocation of any license issued to me by the DHMH. 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 on page 1 of this application.
I further certify that I will notify 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.
I affirm under the penalty of perjury that no employee of this agency or member of the governing body owns property that is leased back to the agency, as per COMAR 10.22.02.08C(9).

SIGNATURE OF CORPORATION ADMINISTRATIVE HEAD	PRINT NAME	DATE
SIGNATURE OF CORPORATION OFFICER	**PRINT NAME**	**DATE**
SIGNATURE OF CORPORATION OFFICER	**PRINT NAME**	**DATE**
SIGNATURE OF EXECUTIVE DIRECTOR	**PRINT NAME**	**DATE**
SIGNATURE OF GOVERNING BODY REPRESENTATIVE	**PRINT NAME/TITLE**	**DATE**
SIGNATURE OF APPLICANT	**PRINT NAME**	**DATE**

FOR OFFICE USE ONLY

INITIALS	DATE	LICENSE NUMBER