COMPREHENSIVE & EXTENDED CARE FACILITIES APPLICATION

INSTRUCTIONS FOR COMPLETION

Incomplete applications will be returned. Prior to submitting the application, ensure it includes all required information and related documentation. Applications should be submitted electronically to:

GENERAL INFORMATION

Applications on behalf of a government unit or agency, corporation, or association shall be made by two officers of the government unit or agency, corporation, or association.

The OHCQ website is. https://health.maryland.gov/ohcq

INITIAL LICENSE

To obtain a license, a complete application form must be submitted with all related documentation listed below.

CHANGE OF OWNERSHIP (CHOW)

Applications for a CHOW of a facility are due 60 days prior to the sale date.

REQUIRED APPLICATION SECTIONS

For an Initial Application or Change of Ownership Complete These Sections	
1. General Information	7. Room & Bed Breakdown
2. Ownership	8. State Affidavit
3. Provider Ownership & Control	9. Medical Director Agreement
4. Adverse Actions/Convictions	10. Principal Physician Agreement
5. Workers' Compensation	11. Relief Physician Agreement
6. Chain Home Office	12. Director of Nursing Agreement

REQUIRED DOCUMENTATION - *INITIAL* APPLICATION AND CHANGE OF OWNERSHIP

1. Certificate of Need (or exemption) from the Maryland Health Care Commission (MHCC). You will need to apply to the MHCC for a pre-certification review. A copy of their review and approval or exemption is required.
2. Evidence of Financial Ability to Operate (see OHCQ website). Alternative formats permitted.
3. Transfer agreement between new ownership and local hospital.
4. Copy of policies and procedures.
5. If your program 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, 410-864-5100 or via e-mail at COC@wcc.state.md.us.
6. Long Term Care Facility Application for Medicare and Medicaid (CMS-671, https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms671.pdf).
7. Completion of a civil rights clearance package, as part of the application for Medicare, must be completed online at https://www.hhs.gov/civil-rights/for-providers/clearance-medicare-providers/index.html.
8. For Medicare facilities only: Health Insurance Benefit Agreement (OMB 0938-0832, see OHCQ website). Two originals required.
9. If applicable, a notice of completion of CHOW (a letter documenting the date the transaction occurred).
10. If the application is made on behalf of a government unit or agency, corporation, or association, submit the names and addresses of all the board members.

PROVIDER OWNERSHIP AND CONTROL DISCLOSURE

This section is applicable to all providers of items or services except for individual practitioners or groups of practitioners.

Pursuant to 42 CFR 455.100 et. Seq., the disclosure of this information is a required portion of the Maryland Medicaid Provider Application. Answer the questions and sign the application affirming that this information is true and complete, attaching continuation sheets if necessary.

Identify any persons named who are related to others named, as spouse, parent, child, or sibling.

Relevant definitions:

"Provider" or "provider of services" means a hospital, a skilled nursing facility, an intermediate care facility, a clinic, a psychiatric facility, a mental institution, an independent clinical laboratory, a health maintenance organization, a pharmacy, and any other entity that furnishes or arranges for the furnishing of services for which payment is claimed under the Medicaid program. It does not include individual practitioners or groups of practitioners.

"Group of practitioners" means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment) but who have not formed a partnership or corporation and are not employees of a person, partnership or corporation, or other entity owning or operating the health care facilities at which they practice.

"Ownership interest" means the possession of equity in the capital of, stock in, or of any interest in the disclosing entity.

"Indirect ownership interest" means any ownership interest in an entity that has ownership interest in the disclosing entity. This term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

"Determination of ownership or control percentage" (1) Indirect ownership interest - The amount of indirect ownership interest in determined by multiplying the percentages of ownership in each entity. For example, if A owns 10% of the stock in the corporation which owns 80% of the stock of the disclosing entity, A's interest equates to an 8% indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80% of the stock of a corporation which owns 5% of the stock of the disclosing entity, B's interest equates to a 4% indirect ownership interest in the disclosing entity and need not be reported. (2) Person with an ownership or control interest - In order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, multiply the percentage of the disclosing entity's assets used to secure the obligation. For example, if A owns 10% of a note secured by 60% of the provider's assets, A's interest in the in the provider's assets equates to 6% and must be reported. Conversely, if B owns 40% of a note secured by 10% of the provider's assets, B's interest in the provider's assets equates to 4% and need not be reported.

"Significant business transaction" means any business transaction or series of transactions that, during any one fiscal year, exceeds the lesser of $25,000 or 5% of the total operating expense of a provider.

"Supplier" means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of a hospital bed, or a pharmaceutical firm).

CHAIN HOME OFFICE

This section captures information regarding chain organization. This information will be used to ensure proper reimbursement when the provider's year-end cost report is filed with the Medicaid fee-for-service contractor.

For more information on chain organizations, see 42 C.F.C. 421.404.

CODE OF MARYLAND REGULATIONS (COMAR) - 10.07.02 COMPREHENSIVE CARE FACILITIES AND EXTENDED CARE FACILITIES

To obtain a copy of the regulations:

A. Visit the Division of State Documents website at www.dsd.state.md.us;
B. Call the Division of State Documents at 410-974-2486 x3876 or 800-633-9657 x3876; or
C. Visit your library - click this link to find the closest location:http://directory.sailor.lib.md.us/

QUESTIONS

Please contact 410-402-8201 for questions related to the application.

SUBMIT COMPLETED INITIAL APPLICATIONS TO:
SUBMIT COMPLETED CHOW APPLICATIONS ELECTRONICALLY TO:

https://app.smartsheet.com/b/publish?EQBCT=94a019649f3649e68af14c6f81fb25a7

COMPREHENSIVE & EXTENDED CARE FACILITIES
APPLICATION FOR LICENSURE

1. GENERAL INFORMATION

CHECK TYPE OF APPLICATION

☐ Initial ☐ Change of Ownership

LEGAL AGENCY NAME	TRADING NAME (DBA)		
LOCATION (Number, Street)	CITY	STATE	ZIP
E-MAIL ADDRESS	PHONE NUMBER	FAX NUMBER	
COUNTY	MEDICAL DIRECTOR'S NAME		

ADMINISTRATOR'S NAME	LICENSE NUMBER	EMAIL ADDRESS	PHONE NUMBER (For 24 hour contact)

TYPE OF FACILITY

☐ Nursing Home Comprehensive Care Facility — NUMBER OF BEDS

☐ Hospital Extended Care Facility — NUMBER OF BEDS

DOES THE FACILITY OPERATE A SPECIAL CARE UNIT? ☐ No ☐ Yes	TYPE	NUMBER OF BEDS

TYPE OF BUSINESS ORGANIZATION

☐ Association ☐ Corporation ☐ Individual ☐ Limited Liability Company ☐ Partnership ☐ Other (specify)

TYPE OF CONTROL

☐ Government: City
☐ Government: County
☐ Government: State
☐ Proprietary
☐ Voluntary Non-Profit: Church
☐ Voluntary Non-Profit: Other (specify)

LEASING ARRANGEMENT (complete only if an entity operates the business under a lease):

EXPIRATION DATE OF LEASE

LESSEE NAME(S) & ADDRESS(ES)

LESSOR NAME(S) & ADDRESS(ES)

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

IF PERCENTAGE OWNED IS 2% OR MORE,
OWNER, PARTNER, OFFICER, DIRECTOR, OR STOCKHOLDER INFORMATION

NAME & TITLE	ADDRESS	EMAIL ADDRESS	% OWNED

3. PROVIDER OWNERSHIP & CONTROL DISCLOSURE (For Title XVIII &/or Title XIX Providers)

PART A

The information in Part A may be submitted in another format as an attachment. Identify the person's name and personal mailing address (not the facility's mailing address), of the people who:

1. ARE OFFICERS OR DIRECTORS:

NAME	ADDRESS
NAME	ADDRESS

2. ARE PARTNERS:

NAME	ADDRESS
NAME	ADDRESS

3. HAVE A DIRECT OR INDIRECT OWNERSHIP INTEREST OF 5% OR MORE:

NAME	ADDRESS
NAME	ADDRESS

4. HAVE A COMBINATION OF DIRECT & INDIRECT OWNERSHIP INTERESTS EQUAL TO 5% OR MORE IN THE PROVIDER:

NAME	ADDRESS
NAME	ADDRESS

5. ARE OWNERS (IN WHOLE OR IN PART) OF AN INTEREST OF 5% OR MORE IN ANY MORTGAGE, DEED OR TRUST, NOTE OR OTHER OBLIGATION SECURED (IN WHOLE OR IN PART) BY THE PROVIDER OR ITS PROPERTY OR ASSETS IF THAT INTEREST EQUALS AT LEAST 5% OF THE VALUE OF THE PROPERTY OR ASSETS OF THE PROVIDER:

NAME	ADDRESS
NAME	ADDRESS

PART B

With respect to any subcontractor in which the Title XIX provider has, directly or indirectly, an ownership or control interest of 5% or more, name any person who falls within the above 5 categories, as applied to the subcontractor, & specify which category they fall within:

NAME	CATEGORY
NAME	CATEGORY

PART C

1. If any person named in response to Part A 1-5 (above) has any of the relationships described in Part A with any Title XIX Provider of items or services other than the applicant, or with any entity that does not participate in Medicaid but is required to disclose certain ownership and control information because of participation in any of the programs established under the Title V, XVII, or XX of the Social Security Act, specify the:

NAME OF THE PERSON	NAME OF THE OTHER PROVIDER	NATURE OF THE RELATIONSHIP
NAME OF THE PERSON	NAME OF THE OTHER PROVIDER	NATURE OF THE RELATIONSHIP

2. If the answer to Part C 1 (above) contains the names of more than two persons, state whether any of those so reported are related to each other as spouse, parent, child, or sibling.

I hereby affirm that this information is true and complete to the best of my knowledge and belief, and that the requested information will be updated as changes occur. I further certify that upon specific request by the Secretary

of the Maryland Department of Health, full and complete information will be supplied within 35 days of the date of the request concerning:

A. The ownership of any subcontractor with which the Title XIX provider has had, during the previous 12 months, business transactions in an aggregate amount in excess of $25,000;

B. Any significant business transactions, occurring during the 5-year period ending on the date of such request, between the provider and any wholly-owned supplier or any subcontractor;

C. The identity of any management company that will operate or contract with the applicant to operate the facility; and

D. The ownership of equipment utilized for direct patient care.

AUTHORIZED SIGNATURE	POSITION	DATE

4. ADVERSE ACTIONS/CONVICTIONS

All adverse legal actions must be reported, regardless of whether any records were expunged or any appeals are pending. The following questions pertain to your organization, under any current or former name or business identity.

1. Was any provider, supplier, or any owner of the provider or supplier, convicted of a Federal or State felony offense that CMS has determined to be detrimental to the best interests of the program and its beneficiaries, within the last 10 years preceding enrollment or revalidation of enrollment? Offenses include: felony crimes against persons and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; financial crimes, such as extortion, embezzlement, income tax evasion, insurance fraud and other similar crimes for which the individual was convicted, including guilty pleas and adjudicated pre-trial diversions; any felony that placed the Medicaid program or its beneficiaries at immediate risk (such as a malpractice suit that results in a conviction or criminal neglect or misconduct); and any felonies that would result in a mandatory exclusion under Section 1128(a) of the Act. ☐ No ☐ Yes
2. Has your organization ever had any misdemeanor conviction, under Federal or State law, related to: (a) the delivery of an item or service under Medicare or a State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service? ☐ No ☐ Yes
3. Has your organization ever had any misdemeanor conviction, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service? ☐ No ☐ Yes
4. Has your organization ever had any misdemeanor conviction, under Federal or State law, related to the interference with or obstruction of any investigation into any criminal offense described in 42 C.F.R. Section 1001.101 or 1001.201? ☐ No ☐ Yes
5. Has your organization ever had any misdemeanor conviction, under Federal or State law, related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance? ☐ No ☐ Yes
6. Has your organization ever had any revocation or suspension of a license to provide health care by any State licensing authority? This includes the surrender of such license while a formal disciplinary proceeding was pending before a State licensing authority. ☐ No ☐ Yes
7. Has your organization ever had any revocation or suspension of accreditation? ☐ No ☐ Yes
8. Has your organization ever had any suspension or exclusion from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program? ☐ No ☐ Yes
9. Does your organization currently have any Medicare payment suspension under any Medicare billing number? ☐ No ☐ Yes
10. Has your organization ever had any Medicare revocation of any Medicare billing number? ☐ No ☐ Yes
11. If you answered "yes" to any question in this section, provide the following information for each adverse action and attach documentation of each action and resolution.

ADVERSE ACTION	DATE	TAKEN BY (Federal or State agency or the court/administrative body that imposed the action)	RESOLUTION (if any)

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. CHAIN HOME OFFICE INFORMATION

CHECK HERE ☐ IF THIS DOES NOT APPLY AND SKIP THIS SECTION

TYPE OF ACTION BEING REPORTED

CHECK ONE	EFFECTIVE DATE	COMPLETE
☐ Provider in chain is enrolling in Medicare for the first time *(Initial Enrollment or Change of Ownership)*		Parts A - D
☐ Provider is no longer associated with the chain organization previously reported		Part A only (identify the former chain home office)
☐ Provider has changed from one chain to another		Parts A - D (identify the new chain home office)
☐ The name of provider's chain home office is changing *(all other information remains the same)*		Part A only

PART A

CHAIN HOME OFFICE'S NAME AS REPORTED TO THE INTERNAL REVENUE SERVICE | TAX IDENTIFICATION NUMBER

BUSINESS STREET ADDRESS (Number, Street)	CITY	STATE	ZIP
E-MAIL ADDRESS	PHONE NUMBER	FAX NUMBER	
FEE-FOR-SERVICE CONTRACTOR	CHAIN NUMBER	COST REPORT YEAR-END DATE (mm/dd)	

PART B

CHAIN HOME OFFICE ADMINISTRATOR'S NAME (first, middle, & last)	TITLE	SOCIAL SECURITY NUMBER	DOB

PART C

CHAIN HOME OFFICE'S TYPE OF BUSINESS STRUCTURE (check one)

- ☐ Government: City
- ☐ Government: City-County
- ☐ Government: County
- ☐ Government: Federal
- ☐ Government: Hospital District
- ☐ Government: State
- ☐ Government: Other (specify)
- ☐ Corporation
- ☐ Individual
- ☐ Partnership
- ☐ Proprietary
- ☐ Voluntary Non-Profit: Church
- ☐ Voluntary Non-Profit: Other (specify)
- ☐ Other (specify)

PART D

PROVIDER'S AFFILIATION TO CHAIN HOME OFFICE (check one)

- ☐ Joint Venture/Relationship
- ☐ Leased
- ☐ Managed/Related
- ☐ Operated/Related
- ☐ Wholly Owned
- ☐ Other (specify)

7. ROOM & BED BREAKDOWN

FLOOR #	UNIT NAME	ROOM TYPE	BED #s	TOTAL BEDS
Example: 2	North	Duplex	201, 203, 205, 207, 209, 211, 213, 215	8
OVERALL TOTAL # OF BEDS:				

BREAKDOWN OF BEDS PER FLOOR:

FLOOR #	TOTAL BEDS	FLOOR #	TOTAL BEDS	FLOOR #	TOTAL BEDS	FLOOR #	TOTAL BEDS
1		4		7		10	
2		5		8		11	
3		6		9		12	
OVERALL TOTAL # OF BEDS:							

8. AFFIDAVIT

I/We Name(s) of Applicants certify that I am/we are 18 years of age or older and of reputable and responsible character do hereby apply for a license to maintain and operate a facility subject to the provisions of Health-General Article, Title 19, Subtitle 3, Annotated Code of Maryland, and to the regulations adopted there under by the Secretary of the Maryland Department of Health.

I certify that the administrative and procedural requirements contained in COMAR 10.07.02 (regulations governing Comprehensive Care Facilities and Extended Care Facilities) in the areas of written administrative and resident care policies, By-laws and other organizational documentation, written agreements with outside resources/consultants, committee meetings, staff qualifications and written development programs such as inservices, equipment maintenance and disaster preparedness have not been substantively altered, revised, or modified, since the previous survey, or if they have, I have notified the Office of Health Care Quality, in writing, before the effective date of the change. I further certify that I will notify the Office of Health Care Quality if there are any future "substantive changes in facility management and operation "as defined in the instructions for completion of the Federal affidavit, that significantly affect policies and procedures, and that notice will be given in writing before the effective date of the change.

I solemnly affirm under the penalties of perjury and upon personal knowledge that the contents of the foregoing application are true and correct. 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) 10.07.02.

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 18 and I am otherwise competent to sign this Affidavit.

SIGNATURE OF APPLICANT	TITLE	DATE
SIGNATURE OF APPLICANT	TITLE	DATE
SIGNATURE OF AUTHORIZED OFFICIAL	TITLE	DATE

9. MEDICAL DIRECTOR AGREEMENT

FACILITY NAME	FACILITY LICENSE NUMBER

Note: The State Department of Health Regulations require that each Comprehensive Care Facility 10.07.02 arrange for a physician to serve as the Medical Director and a qualified alternate to cover periods when his or her services are not available

As Medical Director I agree to the following:

1. I will be responsible for the overall coordination, execution, and monitoring of physician services.
2. I will monitor and evaluate health care outcomes, including clinical and physician services provided to the facility's residents.
3. I will designate an alternate medical director with sufficient training to perform the responsibilities of the medical director as described in the regulations of COMAR 10.07.02.11-1.

SIGNATURE OF MEDICAL DIRECTOR	DATE

MEDICAL DIRECTOR INFORMATION NAME (First, Middle, & Last)	MEDICAL LICENSE NUMBER	PHONE NUMBER	
NUMBER, STREET	CITY	STATE	ZIP