ADULT MEDICAL DAY CARE (AMDC)
APPLICATION FOR LICENSURE

1. GENERAL INFORMATION

CHECK TYPE OF APPLICATION

☐ INITIAL ☐ RENEWAL	☐ CHANGE OF OWNERSHIP ☐ CHANGE OF LOCATION	☐ NAME CHANGE ☐ CHANGE IN CAPACITY

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)		
NAME OF DIRECTOR (Last, First, Middle Initial)			PHONE NUMBER		CELL NUMBER
REGISTERED NURSE ASSUMING OVERSIGHT RESPONSIBILITIES: NAME			LICENSE NUMBER		LICENSE EXPIRATION DATE

BUSINESS HOURS (in HH:MM format)

	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
FROM:							
TO:							

HOURS THAT STAFF ARE PRESENT (in HH:MM format)

	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
FROM:							
TO:							

NUMBER OF PARTICIPANTS	AMDC IS: ☐ Attached to a nursing home ☐ A freestanding building

INDICATE ALL HEALTH CARE SERVICES PROVIDED BY THE CENTER:

SERVICES	SERVICE PROVIDED		
	BY STAFF	THROUGH CONTRACT	BY STAFF & THROUGH CONTRACT
PHYSICAL THERAPY	☐	☐	☐
OCCUPATIONAL THERAPY	☐	☐	☐
SPEECH PATHOLOGY	☐	☐	☐
SOCIAL SERVICES AND COUNSELING	☐	☐	☐
PHYSICIAN SERVICES	☐	☐	☐
LIST OTHER SERVICES:	☐	☐	☐

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

☐ SOLE PROPRIETORSHIP ☐ PARTNERSHIP ☐ CORPORATION
☐ ASSOCIATION ☐ GOVERNMENT UNIT ☐ MERGER ☐ LLP ☐ LLC

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

3. 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).

4. 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 DHMH. 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 the provisions of Health-General Article, Title 19, Subtitle 3, Annotated Code of Maryland and the administrative and procedural requirements pertaining to the Adult Medical Day Care Code of Maryland Regulations (COMAR 10.12.04).

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.

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

FOR OFFICE USE ONLY		
DATE	REGISTRATION #	LICENSE #
COORDINATOR NAME		