**Maryland Department of Health**

**Office of Health Care Quality**

**Application for Assisted Living Program License**

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| **A. Overview of Application Process** | | | | | | | | | | | |
| 1. Complete and submit this application and all required documentation. Incomplete packets may be returned to the applicant. 2. After a complete packet is reviewed and approved by OHCQ, a nurse surveyor will contact you to schedule an on-site inspection. 3. After successful completion of the on-site inspection and all licensure requirements, a license to operate an assisted living program in Maryland will be issued. 4. There is no fee to apply for a license. 5. Submit the application and all attachments to: Office of Health Care Quality, Assisted Living Unit, 7120 Samuel Morse Drive, Second Floor, Columbia, Maryland 21046-3422 | | | | | | | | | | | |
| **B. Assisted Living Program - Definition** | | | | | | | | | | | |
| COMAR 10.07.14.02B(11) defines an “assisted living program” as a residential or facility-based program that provides housing and supportive services, supervision, personalized assistance, health-related services, or a combination of these services to meet the needs of individuals who are unable to perform, or who need assistance in performing, the activities of daily living or instrumental activities of daily living, in a way that promotes optimum dignity and independence for the individuals.  It does not include a nursing home, as defined under Health-General Article, §19-301, Annotated Code of Maryland; a State facility, as defined under Health-General Article, §10-101, Annotated Code of Maryland; a program licensed or approved by the Department under Health-General Article, Title 7 or Title 10, Annotated Code of Maryland; a hospice care program licensed by the Department under Health-General Article, Title 19, Annotated Code of Maryland; services provided by family members; services provided by a licensed residential service agency or licensed home health agency in an individual's own home; or a Certified Adult Residential Environment Program that is certified by the Department of Human Services under Article 88A, §140, Annotated Code of Maryland. | | | | | | | | | | | |
| **C. General Information** | | | | | | | | | | | |
| Legal Name  Click or tap here to enter text. | | | Doing Business As  Click or tap here to enter text. | | | | | | | | |
| Street Address  Click or tap here to enter text. | | | | | | | | | | | |
| City  Click or tap here to enter text. | State  Click or tap here to enter text. | | | | Zip Code  Click or tap here to enter text. | | | Jurisdiction  Choose an item. | | |
| Primary Phone  Click or tap here to enter text. | | | | | After Hours Emergency Phone  Click or tap here to enter text. | | | | | | |
| Assisted Living Email  Click or tap here to enter text. | | | | | Fax Number  Click or tap here to enter text. | | | | | | |
| Assisted Living Website, if applicable  Click or tap here to enter text. | | | | | | | | | | | |
| Name of Assisted Living Manager  Click or tap here to enter text. | | | | Business Email Address  Click or tap here to enter text. | | | | | | | |
| Primary Phone Number  Click or tap here to enter text. | | | | After Hours Emergency Phone Number  Click or tap here to enter text. | | | | | | | |
| Name of Alternate Assisted Living Manager  Click or tap here to enter text. | | | | Business Email Address  Click or tap here to enter text. | | | | | | | |
| Primary Phone Number  Click or tap here to enter text. | | | | After Hours Emergency Phone Number  Click or tap here to enter text. | | | | | | | |
| Name of Delegating Nurse  Click or tap here to enter text. | | | | Business Email Address  Click or tap here to enter text. | | | | | | | |
| Primary Phone Number  Click or tap here to enter text. | | | | After Hours Emergency Phone Number  Click or tap here to enter text. | | | | | | | |
| License Number  Click or tap here to enter text. | | | | Date of License Expiration  Click or tap to enter a date. | | | | | | | |
| **D. Common Ownership Community** | | | | | | | | | | | |
| **"**Common Ownership Community" is defined as (1) a development subject to a declaration enforced by a homeowners' association, as that term is used in state law; (2) a condominium, as that term is used in state law; or (3) a cooperative housing project, as that term is used in state law."    Will this assisted living program operate in a property that is part of a common ownership community, as defined above? Yes No    If yes, has the assisted living owner received all of the required approvals in writing from the common ownership community to operate a business at this location? Yes No | | | | | | | | | | | |
| **E. Information of Partners Owning More than 25 Percent** | | | | | | | | | | | |
| Name of Owner 1  Click or tap here to enter text. | | | | | Title  Click or tap here to enter text. | | | | | | |
| Street Address  Click or tap here to enter text. | | | | | | | | | | | |
| City  Click or tap here to enter text. | | State  Click or tap here to enter text. | | | | Zip Code  Click or tap here to enter text. | | | Percent Owned  Click or tap here to enter text. | | |
| Owner’s Email  Click or tap here to enter text. | | | | | | Owner’s Phone  Click or tap here to enter text. | | | | | |
| Name of Owner 2  Click or tap here to enter text. | | | | | Title  Click or tap here to enter text. | | | | | | |
| Street Address  Click or tap here to enter text. | | | | | | | | | | | |
| City  Click or tap here to enter text. | | State  Click or tap here to enter text. | | | | Zip Code  Click or tap here to enter text. | | | Percent Owned  Click or tap here to enter text. | | |
| Owner’s Email  Click or tap here to enter text. | | | | | | Owner’s Phone  Click or tap here to enter text. | | | | | |
| List additional owners in Section M, Additional Information, Page 5. | | | | | | | | | | | |
| **F. Ownership, If Applicable** | | | | | | | | | | | |
| If the applicant is an individual and is not any of the business entities below, skip this section. | | | | | | | | | | | |
| Type of Entity: LLC LLP Sole Proprietorship Corporation | | | | | | | | | | | |
| If Corporation, Date of Charter  Click or tap here to enter text. | Date of Incorporation  Click or tap to enter a date. | | | | | | FEIN Number  Click or tap here to enter text. | | | |
| Name of Director  Click or tap here to enter text. | Director’s Phone  Click or tap here to enter text. | | | | | | Director’s Email  Click or tap here to enter text. | | | |
| Director’s Street Address  Click or tap here to enter text. | | | | | | | | | | | |
| City  Click or tap here to enter text. | | | | | | | | State  Click or tap here to enter text. | | Zip Code  Click or tap here to enter text. |
| Name of Entity (LLC, LLP, Sole Proprietorship, or Corporation)  Click or tap here to enter text. | | | | | | | | | | | |
| Entity’s Street Address  Click or tap here to enter text. | | | | | | | | | | | |
| City  Click or tap here to enter text. | | | | | | | | State  Click or tap here to enter text. | | Zip Code  Click or tap here to enter text. |
| Entity Email  Click or tap here to enter text. | | | Entity Website  Click or tap here to enter text. | | | | | | | | |

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| **G. Disclosures** | | | |
| If you respond “yes” to any of the questions below, explain your response in Section M, Additional Information.   1. Has the owner, manager, alternate manager, or board member of an assisted living program that has had a license suspended or revoked by the Maryland Department of Health in the past 10 years? Yes No 2. Has an owner, manager, or alternate manager operated, leased, or managed an assisted living facility that had sanctions imposed or deficiencies cited within the last 2 years that have not corrected which present a risk to the health or safety of residents for a currently licensed assisted living facility? Yes No 3. Has the parent company, owner, or officer previously owned or operated a health care facility or agency licensed or surveyed by the Maryland Department of Health’s Office of Health Care Quality? Yes No 4. Has the parent company, owner, or officer had a license revoked, suspended, or denied by the Maryland Department of Health? Yes No 5. Has the parent company, owner, or officer been convicted of a criminal offense involving any program under Title 18, 19, or 20 of the Social Security Act? Yes No 6. Has the applicant or anyone with direct or indirect ownership interest in the assisted living facility been convicted of a felony? Yes No | | | |
| **H. Workers’ Compensation** | | | |
| Complete #1, #2, or #3 below. | | | |
| **1** | If the assisted living program has workers’ compensation, complete the fields below | | |
| Insurance Company  Click or tap here to enter text. | | Effective Date  Click or tap to enter a date. | Expiration Date  Click or tap to enter a date. |
| Policy Number  Click or tap here to enter text. | | Binder Number  Click or tap here to enter text. | |
| **2** | If the assisted living program is a sole proprietorship or partnership that does not have workers’ compensation and does not have any employees attach a Letter of Exemption. | | |
| **3** | If the assisted living program is a corporation or a limited liability company that does not have workers' compensation and does not have any employees attach a Certificate of Compliance. | | |
| For more information, contact the Maryland Workers’ Compensation Commission at <https://www.wcc.state.md.us/Gen_Info/ICR.html>, call 410-864-5293, or email [wccinsur@wcc.state.md.us](mailto:wccinsur@wcc.state.md.us?subject=I%5Fhave%5Fa%5Fquestion). | | | |
| **I. Maryland Assessment and Taxation – Good Standing** | | | |
| The assisted living program must obtain an official letter of good standing from the Maryland Assessment and Taxation Business Express:  <https://egov.maryland.gov/businessexpress/entitysearch>  Search the name of your business, click on the business name, and then click on “Order Document” in the lower right-hand corner of the page. | | | |
| **J. Description of Services** | | | |
| What number of beds is being requested? \_\_\_\_\_\_\_\_\_\_ beds | | | |
| What is the highest level of care that will be provided?  Level 1 (low) refers to a resident needing occasional assistance or support in one or more personal care or health related areas.  Level 2 (moderate) refers to a resident needing a great (substantial) assistance or support in one or more personal care or health related areas.  Level 3 (high) refers to a resident needing extensive and frequent help to ensure that several personal or health related areas are maintained. Note, the assisted living manager of a Level 3 program must meet additional requirements. | | | |
| Will you be operating an Alzheimer’s Disease or Related Disorders Special Care Unit?  Yes No  If yes, there are additional requirements to operate this type of unit. You must complete and submit the Alzheimer’s Disease or Related Disorders Special Care Unit Program Disclosure Form to OHCQ for review and approval. | | | |
| Does the owner, corporation, or partnership operate and manage the assisted living program?  Yes No  If yes, identify the management structure and its relationship to the business owner in Section M, Additional Information. | | | |
| **K. Required Documentation with Initial License Application** | | | |
| All Applicants:   1. Hand drawn sketch of the physical site with each level of the building on a separate 8 ½” x 11” inch sheet of paper - label and include the measurements of all rooms 2. Uniform Disclosure Statement - OHCQ website at <http://dhmh.maryland.gov/ohcq> 3. 4-week menu cycle for a regular diet with documentation by a licensed dietician or licensed nutritionist that the menu is nutritionally adequate 4. Copy of verification that the building is owned, leased, or otherwise under the control of the applicant 5. Copy of approved fire inspection report   All Applicants, if Applicable:   1. Copy of Zoning Approval and/or Use and Occupancy Permit, if applicable 2. Worker’s Compensation: Attach a Letter of Exemption or Certificate of Compliance, if applicable 3. Maryland Assessment and Taxation – Letter of Good Standing, if applicable 4. Alzheimer’s Disease or Related Disorders Special Care Unit Program Disclosure Form, if applicable   If 17 or More Beds:   1. Copy of your program’s food service permit from the local health department 2. Approved physical site plans review from a Maryland State Engineer, 410-767-5926   Specific Local Requirements:   1. Howard County: Submit a current copy of your Howard County Rental License which can be obtained from Inspections, Licenses and Permits, 410-313-3800 (includes the Fire Inspection Report and/or Zoning Permit) 2. Montgomery County: If your program is 3+ beds and is in Montgomery County, obtain and submit a copy of your Montgomery County license to operate 3. Baltimore City: If your program is 1 – 16 beds and is in Baltimore City, submit a copy of your environmental report from the Baltimore City Health Department, 410-396-4428 4. Baltimore County: Submit a copy of your environmental report from the Baltimore Department of Health, 410-887-2243 | | | |
| **L. Documentation Reviewed at the On-site Inspection** | | | |
| Are all areas of the assisted living facility fully constructed? Yes No  If no, list all areas that are not fully constructed and the status of the construction for each area in Section M, Additional Information. | | | |
| At the on-site inspection, the following documents will be reviewed. These documents do not need to be submitted at this time.   1. Assisted living manager’s record demonstrating compliance with all requirements 2. Alternate assisted living manager’s record demonstrating compliance with all requirements 3. Documentation of a completed criminal background check or criminal history records check for the owner, applicant, assisted living manager, alternate manager, other staff, and any household members 4. Delegating nurse’s record demonstrating evidence of a current license, completion of delegating nurse training, and a signed contract 5. Quality assurance plan 6. Business plan and a one-year operating budget which demonstrates financial and administrative ability to operate an assisted living program 7. Copy of your program’s resident agreement 8. Copy of your program’s policies and procedures:  * Bed and Room Assignment Policy * Change in Resident’s Accommodation Procedure * Transferring of Resident to Another Facility Procedure * Resident Discharge Procedure * Resident’s Request to Terminate an Agreement Procedure * Documentation Policies and Procedures to ensure all pertinent information relating to a resident’s condition and preferences is documented and communicated * Complaint and Grievance Procedure * Adult Medical Day Care Policy * Policy and procedures prohibiting abuse, neglect, and financial exploitation * Emergency and Disaster Plan Procedure * Smoking Policy | | | |
| **M. Additional Information** | | | |
| Use this space to clarify any of your previous responses. Attach additional sheets, as needed.  Click or tap here to enter text. | | | |

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| **N. Attestation** | | | |
| 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 Maryland Department of Health. In addition, knowingly and willfully failing to fully and accurately disclose the requested information may result in the denial of a request to become licensed or, where the entity already is licensed, a revocation of that license.  I certify that this assisted living program is in compliance with all applicable federal, State, and local laws and regulations, including the administrative and procedural requirements pertaining to the Assisted Living Programs in COMAR 10.07.14.  I further certify that I will notify OHCQ if there are any future substantive changes in the assisted living operation that written notice will be given before the effective date of the change.  I understand that the license shall be conspicuously posted at the facility. I understand that I may not provide services beyond the licensed bed capacity.  I hereby swear and affirm that I am over the age of 21 and I am otherwise competent to sign this affidavit.  The signature of each applicant is required below. | | | |
| Signature of Applicant 1  Click or tap here to enter text. | | Date  Click or tap to enter a date. |
| Print Full Name  Click or tap here to enter text. | Title  Click or tap here to enter text. | | |
| Signature of Applicant 2  Click or tap here to enter text. | | Date  Click or tap to enter a date. |
| Print Full Name  Click or tap here to enter text. | Title  Click or tap here to enter text. | | |
| Signature of Applicant 3  Click or tap here to enter text. | | Date  Click or tap to enter a date. |
| Print Full Name  Click or tap here to enter text. | Title  Click or tap here to enter text. | | |