**Maryland Department of Health**

**Office of Health Care Quality**

**Application for Health Care Staff Agency License**

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| **A. Health Care Staff Agency - Definition** |
| COMAR 10.07.02B(13) “Health care staff agency” means any person, firm, corporation, partnership, or other business entity engaged in the business of referring health care practitioners as employees or independent contractors to render temporary health care services at a health care facility in the State. “Health care staff agency” does not include a health care staff agency operated by a health care facility or its affiliates solely for the purpose of procuring, furnishing, or referring temporary or permanent health care practitioners for employment at that health care facility or its affiliates; a home health agency regulated under Health-General Article, Title 19, Subtitle 4, Annotated Code of Maryland; or any health care practitioner procuring, furnishing, or referring their own services to a health care facility without the direct or indirect assistance of a health care staff agency. |
| **B. General Information** |
| Legal Agency Name | Doing Business As  |
| Street Address |
| City | State | Zip Code | Jurisdiction |
| Primary Agency Phone  | After Hours Emergency Phone  |
| Agency Email  | Agency Fax Number |
| Agency Website |
| **C. Primary Contact Person** |
| Name  | Title |
| Business Email  | Business Phone  |
| **D. Secondary Contact Person** |
| Name  | Title |
| Business Email  | Business Phone  |
| **E. Ownership** |
| Type of Entity: LLC\_\_\_\_\_ LLP\_\_\_\_\_ Sole Proprietorship\_\_\_\_\_ Corporation\_\_\_\_\_ |
| If Corporation, Date of Charter | Date of Incorporation | FEIN Number |
| Name of Director | Director’s Phone  | Director’s Email |
| Street Address |
| City | State | Zip Code |
| Name of Entity |
| Street Address |
| City | State | Zip Code |
| Entity Email | Entity Website |
| **F. Information of Partners Owning More than 2 Percent** |
| Name of Owner 1 | Title |
| Street Address |
| City | State | Zip Code | Percent Owned |
| Owner’s Email | Owner’s Phone  |
| Name of Owner 2 | Title |
| Street Address |
| City | State | Zip Code | Percent Owned |
| Owner’s Email | Owner’s Phone  |
| Name of Owner 3 | Title |
| Street Address |
| City | State | Zip Code | Percent Owned |
| Owner’s Email | Owner’s Phone  |
| List additional owners in Section K, Additional Information, Page 5.  |
| **G. Disclosures** |
| 1. Does the parent company, owner, or officer currently own or operate a health care facility or agency licensed or surveyed by the Maryland Department of Health’s Office of Health Care Quality (OHCQ)? Yes\_\_\_\_\_ No\_\_\_\_\_
2. Has the parent company, owner, agent, officer, or managerial staff 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\_\_\_\_\_
3. Has the parent company, owner, or officer had a license revoked, suspended, or denied by the Maryland Department of Health? Yes\_\_\_\_\_ No\_\_\_\_\_
4. 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\_\_\_\_\_
5. Has the applicant or anyone with direct or indirect ownership interest in the agency been convicted of a felony? Yes\_\_\_\_\_ No\_\_\_\_\_
 |
| If you responded “yes” to any of the questions above, please explain your response in Section K, Additional Information, Page 5. |
| **H. Workers’ Compensation** |
| Complete #1, #2, or #3 below.  |
| **1** | If the agency has workers’ compensation, complete the fields below |
| Insurance Company | Effective Date | Expiration Date |
| Policy Number | Binder Number |
| **2** | If the agency 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 agency 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. |
| **I. Maryland Assessment and Taxation – Good Standing** |
| The agency 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. Policies and Procedures** |
| What type of health care facilities will you refer health care practitioners as employees or independent contractors to render temporary health care services?  |
| The agency’s policies and procedures must include all of the following items and must be submitted with this application:1. Selecting and verifying the credentials of a health care practitioner referred by the agency
2. Validating the experience of a health care practitioner prior to referral by the agency
3. Tracking and acting on serious or life-threatening complaints received by a client, facility, or the client facility's agent
4. Reporting of an action or condition performed by a health care practitioner as required
5. Verifying the following:
	1. A health care practitioner referred by the agency is of satisfactory health status and has received the necessary testing and immunization as required or requested by the client facility;
	2. Drug screening of a health care practitioner is performed before referral by the agency, if the client facility requires drug screening for facility employees;
	3. Drug testing of a health care practitioner referred by the agency is performed, if there is probable cause to perform a drug test or if a client facility requests a drug test;
	4. Criminal background checks of a health care practitioner are performed before referral by the agency, if the client facility requires criminal background checks for facility employees;
	5. The references of a health care practitioner referred by the agency;
	6. A health care practitioner referred by the agency has I-9 status that permits them to legally work in the United States; and
	7. A health care practitioner has active licensure or certification with the Board
6. Investigating a complaint or grievance presented to an agency by the client facility, an individual receiving services, a representative of the individual receiving services, or any concerned individual that includes a:
	1. Description of how and to whom to file a complaint within the agency;
	2. Description of how and to whom to file a complaint with OHCQ (see OHCQ’s website at <https://health.maryland.gov/ohcq/> and click on the quick link “File a Complaint”);
	3. Commitment to conduct a thorough investigation into any allegation against individuals referred by the agency; and
	4. Mechanism for making completed investigation reports available to OHCQ immediately upon request during inspections
 |
| **K. Additional Information** |
| Use this space to clarify any of your previous responses |
| **M. 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 OHCQ shall be notified of any change in agency ownership, name, or address within 30 calendar days of the change; that I understand that any change in agency ownership, name, or address requires the issuance of a new license; and that I am aware that OHCQ may impose a fine of $100 if the above notification does not occur within 30 calendar days of the change.I certify that this agency is in compliance with all applicable federal, State, and local laws and regulations, including the administrative and procedural requirements in COMAR 10.07.03. I certify that the agency hereby attests that it is in compliance with the federal Civil Rights Act of 1964; the Rehabilitation Act of 1973; the American with Disabilities Act of 1990; and the Drug Free Workplace Act of 1988. 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 | Date |
| Print Full Name | Title |
| Signature of Applicant 2 | Date |
| Print Full Name | Title |
| Signature of Applicant 3 | Date |
| Print Full Name | Title |