

**Maryland Department of Health  
Office of Health Care Quality  
Application for End State Dialysis Center License**

**Instructions**

**Applying for a License**

An end stage renal dialysis center (ESRD) is known as a kidney dialysis center or freestanding renal dialysis center in Maryland.

Prior to operating an end stage renal dialysis center (ESRD) in Maryland, the center must first obtain an ESRD license from the Office of Health Care Quality (OHCQ). Before a person may apply for a license to operate an ESRD, the person shall obtain a certificate of need or an exemption for a certificate of need from the [Maryland Health Care Commission](#) (MHCC) under [Health-General §19-114\(b\)](#).

After obtaining a certificate of need or an exemption, the next step in becoming licensed is to complete this application. The application must be typed. Handwritten applications are not accepted and will be returned to the applicant. Submit the completed application and the required attachments through the “Submit a License Application” link on the [OHCQ website](#). There is no fee to apply for a license.

**Required Attachments:**

1. Submit documentation that the Maryland Health Care Commission has determined that the ESRD has either received a certificate of need or is exempt from the certificate of need requirement. [COMAR 10.05.01.04](#).
2. Written description of the quality assurance program. [COMAR 10.05.01.04](#).
3. Written notice if the facility plans to use an accreditation organization for the initial federal certification survey.
4. [CMS Form 3427A](#)
5. [CMS Form 1561](#)
6. Copy of the CMS Form 855B Approval Letter
7. If OHCQ is performing the initial federal certification survey, submit a [Life Safety Code Attestation Form](#).
8. Letter of Good Standing: The applicant must obtain an official letter of good standing from the [Maryland Department of Assessments and Taxation \(SDAT\) Business Express](#). Search for the name of your business, click on the business name, and then click on “Order Documents” in the lower right-hand corner of the page.
9. Workers’ Compensation: Attach a copy of the declaration page from your Workers’ Compensation coverage.
  - a. Corporations and limited liability companies who are not required to carry Workers’ Compensation insurance coverage must submit a Certificate of Compliance.
  - b. Sole proprietorships and partnerships that do not have any employees and who are not required to have Workers’ Compensation insurance coverage must submit a Letter of Exemption.

- c. For more information, visit the [Maryland Workers' Compensation Commission](#) website, call 410-864-5293, or email [wccinsur@wcc.state.md.us](mailto:wccinsur@wcc.state.md.us).

**On-site Licensure Survey**

1. After OHCQ reviews and approves this application and the required attachments, OHCQ will contact the applicant to schedule an on-site licensure survey.
2. OHCQ surveyors will conduct various tasks during the survey, such as tour of the center; interview of staff; and review of documentation.

**OHCQ Determination of License Application**

OHCQ will make one of the following determinations regarding your license application:

- **License Approval with Conditions:** Federal certification is required for a license without conditions. While federal certification is pending, the applicant will initially receive a license with conditions. After the ESRD is federally certified, a license without conditions will be issued.
  - If there are no deficiencies on the survey, you will receive a written report called a Notice of Compliance and a **License with Conditions** to operate an ESRD.
  - If there are deficiencies, you will receive a Statement of Deficiencies. You have 10 business days to write a Plan of Correction that describes how you will resolve the deficiencies. After your Plan of Correction is accepted by OHCQ, you will receive a **License with Conditions** to operate an ESRD.
- **License Denial:** If you are unable to comply with all of the licensure requirements, then your application will be denied. If the application is denied, the applicant will receive a detailed letter explaining the reason for the denial and your appeal rights.
- **License Application Administratively Closed:** An application is not complete until OHCQ has received all the materials required under [COMAR 10.05.01.04](#) and [COMAR 10.05.04.02](#). OHCQ will hold an application for 180 days from the date of initial receipt, after which the application will be deemed inactive and administratively closed. An applicant whose application is administratively closed may reapply by submitting a new application.

**Withdrawal of Application:** An applicant may withdraw their license application at any time by notifying OHCQ in writing. An applicant may reapply by submitting a new application.

**A. General Information**

Legal Name of ESRD			
Doing Business As or Trade Name			FEIN Number
Street Address			
City	State	Zip Code	County
Business Phone	After Hours Emergency Phone		Fax Number

Business Email		Website	
Name of Administrator	Business Email		Business Phone
Name of Primary Contact for Application		Title of Primary Contact	
Business Email		Business Phone	
Name of Secondary Contact for Application		Title of Secondary Contact	
Business Email		Business Phone	
<b>B. Services</b>			
Name of Medical Director		Maryland Medical License Number	
Business Email		Business Phone Number	
Dialysis services provided: <input type="checkbox"/> Hemodialysis <input type="checkbox"/> Peritoneal Dialysis <input type="checkbox"/> Home Training – Hemodialysis and/or Peritoneal Dialysis <input type="checkbox"/> Home Support – Hemodialysis/Peritoneal Dialysis			
Number of dialysis stations:		Number of isolation rooms:	
Does your facility provide dialysis services in a nursing home? Yes <input type="checkbox"/> No <input type="checkbox"/> If you answered yes, list the names of the nursing homes below.			
Does your facility meet the definition of a hospital-based ESRD facility? A hospital-based ESRD facility is owned and administered by a hospital or critical access hospital and is physically located on the hospital campus. Yes <input type="checkbox"/> No <input type="checkbox"/> If you answered yes, provide the name of the affiliated hospital below.			
Does your facility meet the definition of a satellite renal dialysis facility? A satellite renal dialysis facility is a hospital-owned and hospital-administered ESRD facility that is not located on the campus of the hospital. A single hospital may have several satellite renal dialysis facilities. Yes <input type="checkbox"/> No <input type="checkbox"/> If you answered yes, provide the name of the affiliated hospital below.			

List the normal business hours below:  
 Monday    Tuesday    Wednesday    Thursday    Friday    Saturday    Sunday  
 From:  
 To:

**C. Accreditation and Certification**

Is your facility accredited? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, Name of Accreditation Organization	Date of Accreditation
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Does your facility plan to use the accreditation organization for the initial federal certification survey? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, submit a written notice that the facility plans to use an accreditation organization for the initial federal certification survey.

**D. Ownership: Complete the section that is applicable**

**Sole Proprietorship - Skip this section if applicant is not a sole proprietorship**

Name of Sole Proprietor	Title
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Street Address

City	State	Zip Code
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Business Email	Business Phone	Business Fax
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**Limited Liability Company (LLC) - Skip this section if applicant is not an LLC**

**Non-Maryland LLC:** If this is an LLC formed in a State or territory outside of Maryland (including in Washington DC, Puerto Rico, Guam, and the US Virgin Islands), or in another country, state where the LLC was formed.

Name of Limited Liability Company

Street Address of Principal Office

City	State	Zip Code
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Business Email of Principal Office	Business Phone	Business Fax
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Name of Resident Agent

Street Address

City	State	Zip Code
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Business Email	Business Phone	Business Fax
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Enter the full name, street address, city, state, zip code, and business phone number for each member, owner, or investor directly or indirectly owning 2 percent or more of the applicant.

Full Name	Street Address	Phone Number

**Partnership - Skip this section if applicant is not a partnership**

Type of Partnership:  Limited  General

Name of Partnership

Street Address of Principal Office

City	State	Zip Code
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Business Email of Principal Office	Business Phone	Business Fax
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Name of Resident Agent

Street Address

City	State	Zip Code
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Business Email	Business Phone	Business Fax
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Enter the full name, street address, city, state, zip code, and business phone number for each partner, owner, or investor directly or indirectly owning 2 percent or more of the applicant.

Full Name	Street Address	Phone Number

<b>Corporation - Skip this section if applicant is not a corporation</b>		
Type: _____ Stock Corporation    _____ Nonstock Corporation    _____ Close Corporation		
Is this corporation    _____ For Profit    _____ Non-Profit		
Date of Charter	Date of Articles of Incorporation	
<b>Non-Maryland Corporation:</b> If this is a corporation formed in a State or territory outside of Maryland (including in Washington DC, Puerto Rico, Guam, and the US Virgin Islands) or in another country, state where the corporation was formed.		
Name of Corporation		
Street Address of Principal Office		
City	State	Zip Code
Business Email of Principal Office	Business Phone	Business Fax
Name of Resident Agent		
Street Address		
City	State	Zip Code
Business Email	Business Phone	Business Fax
Enter the full name, street address, city, state, zip code, and business phone number for each director, owner, or investor directly or indirectly owning 2 percent or more of the applicant.		
Full Name	Street Address	Phone Number

## E. 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 \_\_\_\_\_ If you answered yes, please list the name and type of facility in Section F.
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 \_\_\_\_\_ If you answered yes, please list the name and type of facility in Section F.
3. Has the parent company, owner, or officer had a license revoked, suspended, or denied by the Maryland Department of Health? Yes \_\_\_\_\_ No \_\_\_\_\_ If you answered yes, please list the name and type of license in Section F.
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 \_\_\_\_\_ If you are answered yes, please include details of the conviction in Section F.
5. Has the applicant or anyone with direct or indirect ownership interest in the agency been convicted of a felony or a crime involving moral turpitude? Yes \_\_\_\_\_ No \_\_\_\_\_ If you answered yes, please include the details of the conviction in Section F.
6. If the applicant is a corporation, has an owner, director, officer whose conduct caused the revocation of a prior license; or who held the same or similar position in another corporate entity that had its license revoked? Yes \_\_\_\_\_ No \_\_\_\_\_ If you answered yes, please include the details of the revocation in Section F.
7. If the applicant is an individual, has the individual's conduct caused the revocation of a prior license; or who held a position as owner, director, or officer in a corporate entity which had its license revoked; or an individual or corporate applicant that has consented to surrender a license as a result of a license revocation action? Yes \_\_\_\_\_ No \_\_\_\_\_ If you answered yes, please include the details of the revocation in Section F.

**F. Additional Information**

Use this space to clarify any of your responses. Attach additional pages, as needed.

**G. 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 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 certify that this applicant is in compliance with all applicable federal, State, and local laws and regulations.

Corporation or Association: An officer of the corporation or association shall apply for a license on behalf of the entity and shall sign below.

Sole Proprietorship, LLC, and Partnership: The signature of an owner, member, or partner, is required below.

Print Full Name	Title	
Signature of Applicant		Date