Maryland Department of Health
Office of Health Care Quality
Application for a General Hospice License

Instructions

Applying for a License

A person may not operate or represent itself as operating a general hospice care program in Maryland without first obtaining a license from the Office of Health Care Quality (OHCQ). Before a person may apply for a license to operate a general hospice care program, 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. Documentation that the Maryland Health Care Commission has determined that the hospice has either received a certificate of need or is exempt from the certificate of need requirement. COMAR 10.07.21.04.
2. Request for Certification in the Medicare Program, form CMS-417.
3. Confirmation of e-submission of Assurance of Compliance to the HHS Office of Civil Rights.
4. Health Insurance Benefit Agreement, form CMS-1561.
5. CMS Form 855A Approval Letter.
6. Written notice if the facility plans to use an accreditation organization for the initial federal certification survey.
7. 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.
8. 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.

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 a tour of the hospice; 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 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 all licensure requirements are met.
  - 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 a hospice.
  - 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 a hospice.
- **License without Conditions:** After the hospice is federally certified and all licensure requirements are met, a license without conditions will be issued.
- **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 10.07.21.04. 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

Type of Application: _____Initial _____Change of Ownership			
Legal Name of Hospice			
Doing Business As or Trade Name			FEIN Number
Street Address of Principal Office			
City	State (Select O1	Zip Code	County (Select One)
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. Services

Select all of the counties that the hospice will provide services in:

__ Allegany	__ Carroll	__ Harford	__ Somerset
__ Anne Arundel	__ Cecil	__ Howard	__ St. Mary's
__ Baltimore City	__ Charles	__ Kent	__ Talbot
__ Baltimore County	__ Dorchester	__ Montgomery	__ Washington
__ Calvert	__ Frederick	__ Prince George's	__ Wicomico
__ Caroline	__ Garrett	__ Queen Anne's	__ Worcester

Name of Medical Director	Business Email	Business Phone

Does the agency plan to operate a hospice-owned inpatient unit? Yes____ No_____

If yes, how many beds? _____ beds	Inpatient Unit Phone

Street Address of Inpatient Unit

City	State (Select	Zip Code	County (Select One)

Hospice Does Not Own Inpatient Space: If the applicant proposes to operate a facility providing inpatient hospice care services and someone other than the applicant owns the building or real property, or both, list the name and address of the owner or owners below. If the hospice owns the inpatient space, skip this section.

Name of Owner

Street Address of Owner

City	State (Select	Zip Code	County (Select One)

C. Accreditation

Is the applicant requesting the accreditation organization or OHCQ conduct the initial federal certification survey? Accreditation Organization_____ OHCQ_____

Accreditted: Yes_____ No_____	If yes, Name of Accreditation Organization	If yes, Date of Accreditation
Deemed Status? Yes_____ No_____	If yes, Name of Deeming Agency	If yes, Date of Deemed Status

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	
Street Address		
City	State (Select One)	Zip Code
Business Email	Business Phone	Business Fax

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 (Select One)	Zip Code
Business Email of Principal Office	Business Phone	Business Fax
Name of Resident Agent		
Street Address		
City	State (Select One)	Zip Code
Business Email	Business Phone	Business Fax

Enter the full name, street address, city, state, zip code, and business phone number for each member, owner, or investor directly or indirectly owning 5 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 (Select One)	Zip Code
Business Email	Business Phone	Business Fax

Name of Resident Agent
Street Address

City	State (Select One)	Zip Code
Business Email	Business Phone	Business Fax

Enter the full name, street address, city, state, zip code, and business phone number for each partner, owner, and investor directly or indirectly owning 5 percent or more of the applicant.

Full Name	Street Address	Phone Number

Corporation - Skip this section if applicant is not a corporation

Type: _____Stock Corporation _____Nonstock Corporation _____Close Corporation

Is this corporation _____For Profit _____Non-Profit

Date of Charter	Date of Articles of Incorporation

Non-Maryland Corporation: 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 (Select One)	Zip Code
Business Email	Business Phone	Business Fax

Name of Resident Agent		
Street Address		
City	State (Select One)	Zip Code
Business Email	Business Phone	Business Fax

Enter the full name, street address, city, state, zip code, and business phone number for the Director, President, Secretary, and Treasurer.

Full Name	Street Address	Phone Number

Enter the full name, street address, city, state, zip code, and business phone number of every owner and investor directly or indirectly owning 5 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 been convicted of a felony involving a nursing home or its residents? Yes_____ No_____ If you answered yes, please include the details of the conviction in Section F.

F. Additional Information

Use this space to clarify any of your responses. Attach additional sheets, 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, including the requirements of Health-General Article, Title 19, Annotated Code of Maryland, and COMAR 10.07.21.

The signature of an owner, member, partner, or officer is required below.

Full Name of Applicant	Title
Signature of Applicant	Date