

Maryland Department of Health
Office of Health Care Quality
Application for Assisted Living Program License

Step One: Submit Initial License Application and Attachments

Prior to operating an assisted living program in Maryland, the program must first obtain an assisted living program license from the Office of Health Care Quality (OHCQ). COMAR 10.07.14.04.

The first step in the licensure process is to complete this application. Steps two and three are detailed on pages 9 and 10 of this application form. Please do not proceed to step two until OHCQ staff notifies you that the initial application and attachments are complete and reviewed.

All application materials must be typed. Handwritten applications are not accepted and will be returned to the applicant.

Submit this 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. Documents that verify that the building is owned, leased, or otherwise under the control of the applicant. [COMAR 10.07.14.07](#).
2. Written approval from the common ownership community, if applicable (see Section C).
3. Business plan and a one-year operating budget which demonstrates financial and administrative ability to operate an assisted living program. [COMAR 10.07.14.07](#).
4. 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.
5. If the applicant is establishing an Alzheimer’s Special Care Unit, complete the [Alzheimer’s Special Care Unit Disclosure Form](#) (see Section B).

Change of Ownership or Relocation

Change of Ownership: If a sale, transfer of ownership, or lease of a facility causes a change in the person or persons who control or operate the assisted living program, the new owner shall apply for a new license. The new owner shall file a complete application for an initial license at least 45 days before the final transfer of ownership. The new owner must apply for and receive a new license prior to operating the assisted living program. See [COMAR 10.07.14.08](#).

Relocation: The license is valid only for the premises listed on the license. If an assisted living program relocates to a new address, the owner shall file a complete application for an initial license and receive that license prior to operating the assisted living program at the new location. See [COMAR 10.07.14.08](#).

A. General Information

Type of Application: Initial Change of Ownership Relocation

Legal Name of Business:

Doing Business As or Trade Name:

FEIN Number:

Street Address:

City, State, Zip Code:

County:

Primary Business Phone:

After Hours Emergency Phone Number:

Fax Number:

Assisted Living Email:

Assisted Living Website:

Name of Assisted Living Manager (ALM):

ALM's Business Email:

Business Phone of ALM:

After Hours Phone of ALM:

Name of Alternate Assisted Living Manager (AALM):

AALM's Business Email:

Business Phone of AALM:

After Hours Phone of AALM:

Name of Delegating Nurse (DN):

Business Email of DN:

Business Phone of DN:

DN After Hours Phone:

DN License Number:

License Expiration Date:

B. Services

What number of beds is being requested? _____ beds

What is the highest level of care that will be provided?

Level 1 (Low) Level 2 (Moderate) Level 3 (High)

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 Special Care Unit Disclosure Form](#) to

OHCQ for review and receive OHCQ's written approval prior to operating the unit.

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 below.

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C. Common Ownership Community

Under Maryland law, a "Common Ownership Community" includes (1) a development subject to a declaration enforced by a homeowners' association, (2) a condominium, or (3) a cooperative housing project.

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 an assisted living program at this location? Yes No

All required written approvals from the common ownership community must be submitted with this application.

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, and 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 U.S. Virgin Islands), or in another country, state where the LLC was formed.

Name of Limited Liability Company:

Street Address of Principal Office:

City, State and Zip Code:

Business Email of Principal Office:

Business Phone:

Business Fax:

Name of Resident Agent:

Street Address:

City, State, and 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 or other entity or individual owning more than 25 percent interest in the applicant.
Full Name of Member 1:
Street Address for Member 1:
Phone Number for Member 1:
Full Name of Member 2:
Street Address of Member 2:
Phone Number of Member 2:
Full Name of Member 3:
Street Address of Member 3:
Phone Number of Member 3:
Full Name of Member 4:
Street Address of Member 4:
Phone Number of Member 4:
Full Name of Member 5:
Street Address of Member 5:
Phone Number of Member 5:
Partnership - Skip this section if applicant is not a partnership
Type of Partnership: <input type="checkbox"/> Limited <input type="checkbox"/> General
Name of Partnership:
Street Address of Principal Office:
City, State, and Zip Code:
Business Email of Principal Office:
Business Phone:
Business Fax:
Name of Resident Agent:
Street Address:
City, State, and 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 or other entity or individual owning more than 25 percent interest in the applicant.
Full Name of Partner 1:
Street Address for Partner 1:
Phone Number for Partner 1:
Full Name of Partner 2:
Street Address for Partner 2:
Phone Number for Partner 2:
Full Name of Partner 3:

Street Address for Partner 3:
Phone Number for Partner 3:
Full Name of Partner 4:
Street Address for Partner 4:
Phone Number for Partner 4:
Full Name of Partner 5:
Street Address for Partner 5:
Phone Number for Partner 5:
Corporation, if applicable
Type of Corporation: <input type="checkbox"/> Stock Corporation <input type="checkbox"/> Tax Exempt Nonstock Corporation <input type="checkbox"/> Close Corporation
Type of Corporation: <input type="checkbox"/> For Profit <input type="checkbox"/> 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 the State of Maryland (including in Washington DC, Puerto Rico, Guam, and the US Virgin Islands) or in another country, where was the corporation formed?
Name of Corporation:
Street Address of the 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 the Director, President, Secretary, and Treasurer.
Full Name of Director:
Street Address of Director:
Phone Number of Director:
Full Name of President:
Street Address of President:
Phone Number of President:
Full Name of Secretary:
Street Address of Secretary:
Phone Number of Secretary:

Full Name of Treasurer:
Street Address of Treasurer:
Phone Number of Treasurer:
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 of Partner 1:
Street Address for Partner 1:
Phone Number for Partner 1:
Full Name of Partner 2:
Street Address of Partner 2:
Phone Number of Partner 2:
Full Name of Partner 3:
Street Address of Partner 3:
Phone Number of Partner 3:
Full Name of Partner 4:
Street Address of Partner 4:
Phone Number of Partner 4:
Full Name of Partner 5:
Street Address of Partner 5:
Phone Number of Partner 5:
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)? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If you answered yes, please list the name and type of facility in Section F.
3. Has the parent company, owner, officer, manager, alternate manager, or board member had a license revoked, suspended, or denied by the Maryland Department of Health? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If you 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If you answered yes, please include the details of the conviction in Section F.

6. Has the parent company, owner, or officer ever operated or owned a residential or facility-based program that provides housing and supportive services, supervision, personalized assistance, and/or health-related services to meet the needs of individuals who are unable to perform or need assistance with the activities of daily living or instrumental activities of daily living? Yes No If yes, please include the details 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 this applicant is in compliance with all applicable federal, State, and local laws and regulations, including the State administrative and procedural requirements governing Assisted Living Programs in [COMAR 10.07.14](#).

I further certify that I will notify OHCQ, in writing, of any substantive changes in the assisted living operation before the effective date of the change in accordance with [COMAR 10.07.14](#).

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 understand that I may not operate an Alzheimer's Special Care Unit prior to written approval from OHCQ.

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 an owner, member, partner, or officer is required below.

Full Name of Applicant:

Title of Applicant:

Signature of Applicant:

Date:

Step Two – Submit Additional Documentation

The applicant may not proceed to Step Two until OHCQ staff notifies you that the initial application and attachments are complete and reviewed. OHCQ will send you instructions on proceeding with your license application which requires submitting the following documents:

1. **Physical Site Plan:** If fewer than 17 beds, the applicant may submit a blueprint or a hand drawn sketch of the physical site with each level of the building on a separate 8.5 x 11 inch sheet of paper. For each room, clearly label the measurements and purpose for each. If there are 17 or more beds, you must include an approved physical site plan review from a Maryland State Engineer, 667-203-9124.
2. Use and Occupancy Permit or Zoning Approval from your local jurisdiction.
3. Copy of approved fire inspection report: 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. If your program is in Baltimore County, submit a copy of your environmental report from the Baltimore County Department of Health, 410-887-2243.
4. A food service permit from the local health department must be submitted if the applicant is requesting 17 or more beds.
5. [Uniform Disclosure Statement](#): This form is found on the OHCQ website.
6. [Resident Agreement](#): A sample template is found on the OHCQ website.
7. **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.

Step Three - On-Site Survey

After OHCQ reviews and approves Steps One and Two of the application and all required attachments, OHCQ staff will contact you to schedule an on-site survey. The surveyor will conduct various tasks during the on-site survey, including a tour of the building; interview of staff; and review of documentation.

The surveyor's review of records will include, but is not limited to, a review of the following documents:

1. 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. [COMAR 10.07.14.07](#).
2. Assisted living manager: Documentation of compliance with all requirements.
3. Alternate assisted living manager: Documentation of compliance with all requirements
4. Delegating nurse: Documentation of a current nursing license, completion of delegating nurse training, and a signed contract.
5. Policies and procedures:
 - a. Bed and Room Assignment Policy

- b. Change in Resident's Accommodation Procedure
 - c. Transferring of Resident to Another Facility Procedure
 - d. Resident Discharge Procedure
 - e. Resident's Request to Terminate an Agreement Procedure
 - f. Documentation Policies and Procedures to ensure all pertinent information relating to a resident's condition and preferences is documented and communicated
 - g. Complaint and Grievance Procedure
 - h. Adult Medical Day Care Policy
 - i. Abuse, Neglect, and Financial Exploitation Policy
 - j. Smoking Policy
 - k. Emergency and Disaster Plan
 - l. Quality Assurance Plan
6. 4-week menu cycle for a regular diet with written documentation from a licensed dietician or licensed nutritionist that the menu is nutritionally adequate.

Once the on-site survey is completed, OHCQ will make one of the following determinations regarding your license application:

- **License Approval:** If there are no deficiencies on the survey, you will receive a written report called a Notice of Compliance and a license to operate an assisted living program. 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 to operate an assisted living program. After OHCQ determines that the applicant is in compliance with all licensure requirements, a license is issued to the applicant.
- **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 the Department has received all the materials required in this application. OHCQ will hold the 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.