Maryland Department of Health
Office of Health Care Quality
Application for an Adult Medical Day Care License

Licensure Process

Step 1: Submit a Letter of Interest

A person may not establish, operate, or continue the operation of an adult medical day care center (AMDC) without first obtaining a license from the Office of Health Care Quality (OHCQ). A person desiring to obtain initial licensure for an AMDC shall submit a letter of interest to OHCQ. After OHCQ reviews and approves the Letter of Interest and information, OHCQ will notify the applicant to proceed with submitting an Application for an Adult Medical Day Care License (this application). This application will not be accepted until OHCQ reviews and approves the Letter of Interest. COMAR 10.12.04.04A.

Step 2: Submit an Application for an Adult Medical Day Care License

After OHCQ notifies the applicant that the Letter of Interest and required information has been approved, the applicant may proceed with the application. The applicant completes and submits this application with all required attachments through the link provided to the applicant by OHCQ. The documents must be typed. Handwritten documents are not accepted and will be returned to the applicant. There is no fee to apply for a license.

Required Attachments:

1. 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.
2. 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 3: OHCQ Conducts an On-site Survey

After OHCQ reviews and approves the application and all attachments, OHCQ staff will contact the applicant to schedule an on-site survey. The surveyor will conduct various tasks during the survey, including a tour of the building, interview of staff, and review of documentation. After the on-site survey is completed, OHCQ will make one of the following determinations regarding the license application:

- **License Approval:**

o If there are no deficiencies identified in the survey, the applicant will be issued a written report called a Notice of Compliance and a license to operate an AMDC.
o If there are deficiencies, the applicant will be issued a Statement of Deficiencies. The applicant has 10 business days to submit a Plan of Correction to OHCQ that describes how the deficiencies will be resolved. After OHCQ reviews and accepts the Plan of Correction, the applicant will be issued a license to operate an AMDC.

• **License Denial:** If the applicant is unable to submit an acceptable plan of correction or comply with all of the licensure requirements, then the application will be denied. The applicant will receive a letter explaining the basis for the denial and their appeal rights.

• **License Application Administratively Closed:** An application is not complete until OHCQ has received all of the required documents. OHCQ will hold an application for 180 days from the date of initial receipt, after which an incomplete 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.

Change of Ownership or Relocation

When there is a change of program ownership or control or a change of location, the new owner-operator shall submit an Application for an Adult Medical Day Care License (this application).

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:	
Business Email:	
Business Website:	
Name of Director:	
Director's Business Email:	
Business Phone of Director:	
After Hours Phone of Director:	
Name of Registered Nurse (RN) assuming oversight:	

License Number:
Expiration Date:
Business Email of RN:
Business Phone of RN:
After Hours Phone:
B. Services
The number of participants cared for at any one time in a center may not exceed the licensed capacity of the center. What is the number of participants requested? participants (slots)
List the normal business hours that the AMDC will provide services below:
Monday:
Tuesday:
Wednesday:
Thursday:
Friday:
Saturday:
Sunday:
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: ☐ Limited ☐ General
Name of Partnership:
Street Address of Principal Office:
City, State, and Zip Code:
Business Email of Principal Office:
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: ☐ Stock Corporation ☐ Tax Exempt Nonstock Corporation ☐ Close Corporation
Type of 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 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 member, owner, or investor directly or indirectly owning 2 percent or more of 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:

E. Disclosures

1. Does the parent company, owner, or officer currently own or operate a health care facility 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 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 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 applicant been convicted of a felony? ☐ 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 applicant 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 ambulatory surgery center 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.

Full Name of Applicant:
Title of Applicant:
Signature of Applicant:
Date: