

**Maryland Department of Health**  
**Office of Health Care Quality**  
**Application for Ambulatory Surgical Center License**

**Instructions**

**Applying for a License**

The Centers for Medicare & Medicaid Services certifies ambulatory surgical centers (ASC). In Maryland, ASCs are known as freestanding ambulatory surgical facilities.

Prior to establishing or operating an ambulatory surgical center (ASC) in Maryland, the center must first obtain an ASC license from the Office of Health Care Quality (OHCQ). Prior to applying for a license, the applicant must apply for and receive either a Certification of Need (CON) or Determination of Coverage from the [Maryland Health Care Commission](#) (MHCC).

- CON Approval Letter: If three or more operating rooms are planned, the applicant must receive CON approval from MHCC. [Health-General §19-114\(b\)](#).
- Determination of Coverage Letter: If less than three operating rooms are planned, the applicant must seek a determination from MHCC that a proposed center does not require CON review and approval.

After obtaining a CON Approval Letter or a Determination of Coverage Letter from MHCC, 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 an 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 ASC has either received a certificate of need or a determination of coverage letter [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 377](#), Ambulatory Surgical Center Request for Initial Certification.
5. [CMS Form 370](#): Health Insurance Benefit Agreement.
6. Novitas Notice of Approval of CMS Form 855B.
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](mailto:wccinsur@wcc.state.md.us).

| <b>On-site Licensure Survey and Conditional License</b>  |
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| <ol style="list-style-type: none"> <li>1. After OHCQ reviews and approves this application and the required attachments, OHCQ will contact the applicant to schedule an on-site licensure survey.</li> <li>2. OHCQ surveyors will conduct various tasks during the survey, such as a tour of the center; interview of staff; review of documentation; and review facility's policies and procedures (see COMAR 10.05.05 and COMAR 10.05.01).</li> </ol>  |
| <b>OHCQ Determination of License Application</b>   |
| <p>OHCQ will make one of the following determinations regarding your license application:</p> <ul style="list-style-type: none"> <li>• <b>License Approval with Conditions:</b> 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 ASC is federally certified, a Non-Expiring License will be issued. <ul style="list-style-type: none"> <li>o 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 ASC.</li> <li>o 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 ASC.</li> </ul> </li> <li>• <b>License Denial:</b> 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.</li> <li>• <b>License Application Administratively Closed:</b> An application is not complete until OHCQ has received all the materials required under COMAR 10.05.01.04. 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.</li> </ul> <p><b>Withdrawal of Application:</b> An applicant may withdraw their license application at any time by notifying OHCQ in writing. An applicant may reapply by submitting a new application.</p> |
| <b>A. General Information</b>  |
| Type of Application: <input type="checkbox"/> Initial <input type="checkbox"/> Change of Ownership <input type="checkbox"/> New Service  |
| Legal Name of Center:  |
| Doing Business As or Trade Name:   |
| FEIN Number:   |
| Street Address:  |
| City, State, Zip Code:   |
| County:  |
| Primary Business Phone:  |

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| After Hours Emergency Phone Number:   |
| Fax Number:   |
| Business Email:   |
| Website:  |
| Name of Administrator:  |
| Administrator's Business Email:   |
| Administrator's Business Phone:   |
| Name of Primary Contact:  |
| Title of Primary Contact:   |
| Business Email of Primary Contact:  |
| Business Phone of Primary Contact:  |
| Name of Secondary Contact:  |
| Title of Secondary Contact:   |
| Business Email of Secondary Contact:  |
| Business Phone of Secondary Contact:  |
| <b>B. Services</b>  |
| Select the facility type: <input type="checkbox"/> Freestanding Ambulatory Surgery Center<br><input type="checkbox"/> Freestanding Endoscopy Center   |
| Select all the services that the applicant will be providing.<br><br><input type="checkbox"/> Cardiovascular<br><input type="checkbox"/> Colon and Rectal<br><input type="checkbox"/> Endoscopy<br><input type="checkbox"/> GI Procedures<br><input type="checkbox"/> General<br><input type="checkbox"/> Lower GI Procedures<br><input type="checkbox"/> Neurological<br><input type="checkbox"/> OB/GYN<br><input type="checkbox"/> Ophthalmology<br><input type="checkbox"/> Oral<br><input type="checkbox"/> Orthopedic<br><input type="checkbox"/> Other GI Procedures<br><input type="checkbox"/> Otolaryngology<br><input type="checkbox"/> Pain Management<br><input type="checkbox"/> Plastic Surgery<br><input type="checkbox"/> Podiatric<br><input type="checkbox"/> Thoracic<br><input type="checkbox"/> Upper GI<br><input type="checkbox"/> Urology<br><input type="checkbox"/> Other (specify): |

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| Number of Procedure Rooms:   |
| Number of Operating Rooms:   |
| <b>C. Accreditation</b>  |
| Is the applicant accredited? <input type="checkbox"/> Yes <input type="checkbox"/> No  |
| If yes, Name of Accreditation Organization:  |
| Date of Accreditation:   |
| Is the applicant requesting the accreditation organization with deeming authority or OHCQ conduct the initial federal certification survey? <input type="checkbox"/> Accreditation Organization <input type="checkbox"/> OHCQ      |
| <b>D. Ownership: Complete the section that is applicable</b>   |
| <b>Sole Proprietorship - Skip this section if applicant is not a sole proprietorship</b>   |
| Name of Sole Proprietor:   |
| Title:   |
| Street Address:  |
| City, State, and Zip Code:   |
| Business Email:  |
| Business Phone:  |
| Business Fax:  |
| <b>Limited Liability Company (LLC) - Skip this section if applicant is not an LLC</b>  |
| <b>Non-Maryland LLC:</b> 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, owner, or investor directly or indirectly owning 25 percent or more of the applicant.                                       |
| Full Name of Member 1:   |
| Street Address for Member 1:   |

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| 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:   |
| <b>Partnership - Skip this section if applicant is not a partnership</b>  |
| 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:   |
| Enter the full name, street address, city, state, zip code, and business phone number for each partner, owner, or investor directly or indirectly owning 25 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 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:   |

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| <b>Corporation, if applicable</b>  |
| Type of Corporation:<br><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:   |
| <b>Non-Maryland Corporation:</b> 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:   |

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| 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 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 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: