Maryland Department of Health
Office of Health Care Quality
Application for a Comprehensive Outpatient Rehabilitation Facility License

Instructions

Applying for a License

Prior to providing or holding itself out as providing in-patient or out-patient comprehensive physical rehabilitation services in Maryland, a person must first obtain a comprehensive outpatient rehabilitation facility (CORF) license from the Office of Health Care Quality (OHCQ).

The first 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. Disclosure of ownership of applicant's property, real estate, and equipment (if the applicant is not the owner).
2. Form CMS-1561 - Health Insurance Benefit Agreement.
3. Form CMS-690 - Assurance of Compliance.
4. Form CMS-359 - CORF Report for Certification to Participate in the Medicare Program.
5. Novitas Solutions 855 Recommendation of Approval.
6. A copy of the CARF accreditation letter.
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 facility; 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:**
  - 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 CORF.
  - 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 CORF.
- **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 under COMAR 10.07.18.04. 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.

Separate License Required

Separate licenses are required for institutions maintained on separate premises, even though each institution may be operated under the same management. COMAR 10.07.18.04F.

A. General Information

Legal Name of CORF:
Doing Business As or Trade Name:
FEIN Number:
Street Address:
City, State, Zip Code:
County:
CORF Business Phone:
After Hours Emergency Phone:
Fax Number:
Website:
Name of Administrator:
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. Services
"Comprehensive physical rehabilitation services" is defined as a program of coordinated, integrated, interdisciplinary, physician-directed services provided by or under the supervision of physicians qualified or experienced in rehabilitation that: 1. Includes evaluation and treatment of individuals with physical disabilities; 2. Emphasizes education and training of individuals with disabilities; 3. Incorporates at least 4 of the following core disciplines; and 4. At least 2 other disciplines.
Indicate which core disciplines are provided (4 or more disciplines are required): ☐ Physical therapy ☐ Occupational therapy ☐ Speech and language therapy ☐ Psychotherapy ☐ Rehabilitation nursing ☐ Social work
Indicate which other disciplines are provided (at least 2 other disciplines are required): ☐ Psychology ☐ Audiology ☐ Respiratory therapy ☐ Therapeutic recreation ☐ Orthotics ☐ Prosthetics ☐ Special education or instruction ☐ Vocational rehabilitation
List the normal business hours below:
Monday:
Tuesday:
Wednesday:
Thursday:
Friday:
Saturday:
Sunday:
C. CARF Accreditation
Are you accredited by CARF? ☐ Yes ☐ No
Date of Accreditation:

If not accredited yet, what date was the accreditation application submitted to CARF?
A CORF may only provide specialized rehabilitation programs that have been accredited by CARF. List all CARF accredited specialized rehabilitation programs that the facility will offer.

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, 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:
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:
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, 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 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 of every owner and investor directly or indirectly owning 2 percent or more of the applicant.
Full Name of Owner 1:
Street Address for Owner 1:
Phone Number for Owner 1:
Full Name of Owner 2:
Street Address for Owner 2:
Phone Number for Owner 2:
Full Name of Owner 3:
Street Address for Owner 3:
Phone Number for Owner 3:
Full Name of Owner 4:
Street Address for Owner 4:
Phone Number for Owner 4:
Full Name of Owner 5:
Street Address for Owner 5:
Phone Number for Owner 5:

F. 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 facility 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 facility 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 CORF is in compliance with all applicable federal, State, and local laws and regulations.

The signature of two officers of the corporation, or governmental unit or agency of the applicant is required below.

Full Name of Applicant 1:
Title of Applicant 1:
Signature of Applicant 1:
Date of Signature of Applicant 1:
Full Name of Applicant 2:
Title of Applicant 2:
Signature of Applicant 2:
Date of Signature of Applicant 2: