Maryland Department of Health
Office of Health Care Quality
Application for Freestanding Medical Facility License

Instructions

Applying for a License

A hospital may not establish, operate, or continue to operate an existing freestanding medical facility (FMF) without first obtaining a license from the Office of Health Care Quality (OHCQ). Before a person may apply for a license to operate a FMF, the person shall obtain a certificate of need or an exemption for a certificate of need from the Maryland Health Care Commission under Health-General Article, Title 19, Annotated Code of Maryland.

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 FMF has either received a certificate of need or is exempt from the certificate of need requirement.
2. Documentation regarding accreditation of the affiliated hospital. COMAR 10.07.08.08.
3. 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.
4. 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 to operate an FMF. 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 FMF.
- **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 10.07.08.04. 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

Legal Name of FMF:
Doing Business As or Trade Name:
FEIN Number:
Street Address:
City, State, Zip Code:
County:
Business Phone:
After Hours Emergency Phone:
Business Email:
Fax Number:
Website:
Name of Administrator Director:
Business Email:
Administrator Director's Business Phone:
Name of Medical Director:
Medical Director's Business Email:
Medical Director'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. Affiliated Hospital
Name of Affiliated Hospital:
Street Address of Affiliated Hospital:
Affiliated Hospital City, State, Zip Code:
Contact Person at Affiliated Hospital:
Title of Contact Person:
Contact Person's Business Email:
Contact Person's Business Phone:
Was the CMS 855A form submitted to Novitas to add the FMF as a provider-based location? ☐ Yes ☐ No If yes, what date was it submitted to Novitas?
C. Accreditation
Accreditation organization of the affiliated hospital: ☐ The Joint Commission ☐ DNV
If accredited, what is the effective date of accreditation?
If accreditation is pending, what is the date the application was submitted?
D. 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 E. 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 E. 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 E. 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 E. 5. Has the applicant or anyone with direct or indirect ownership interest in the affiliated hospital been convicted of a felony or a crime involving moral turpitude? ☐ Yes ☐ No If you answered yes, please include the details of the conviction in Section E.

E. Additional Information

Use this space to clarify any of your responses. Attach additional sheets, as needed.

F. 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 facility is in compliance with all applicable federal, State, and local laws and regulations. I certify that the proposed freestanding medical facility meets the requirements of Health-General Article, Title 19, Subtitle 3.

I certify that the governing body of the affiliated hospital shall provide administrative and clinical oversight for the care and services provided by the proposed freestanding medical facility. I also certify that services of the proposed freestanding medical facility shall be reviewed and monitored consistent with the hospital's bylaws, including but not limited to patient safety, peer review, medical staff, risk management, and quality improvement.

The signature of an owner, member, partner, or officer is required below.
Print Full Name:
Title:
Signature of Applicant:
Date of Signature of Applicant :