Maryland Department of Health
Office of Health Care Quality
Application for a Home Health Agency License

Instructions

Applying for a License

A person, partnership, corporation, or association, or any State or local government or agency thereof, may not conduct, operate, or maintain a home health agency in Maryland without being licensed by the Office of Health Care Quality (OHCQ). Before a person may apply for a license to operate a home health agency, the person shall obtain a certificate of need or an exemption for a certificate of need from the Maryland Health Care Commission (MHCC) under Health-General §19–114(b).

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 home health agency has either received a certificate of need or is exempt from the certificate of need requirement. COMAR 10.24.01
2. List of the names of those that serve on the Professional Advisory Group.
3. Civil Rights Information Request.
4. Proof of accreditation (award letter and the most recent full survey report) or proof of application for accreditation.
5. Written notice if the facility plans to use an accreditation organization for the initial federal certification survey.
6. Procedures listed in COMAR 10.07.10.04.
7. Attach a copy of the declaration page from your general liability insurance coverage.
8. 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.
9. 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 agency; 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 a home health agency. 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 a home health agency.
    - **Provisional License:** In certain circumstances, OHCQ may issue a provisional license. COMAR 10.07.10.06.
- **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 OHCQ has received all the materials required under COMAR 10.07.10.04. 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.

Parent Agency Outside of Maryland

Per COMAR 10.07.10.04, if a parent agency is located outside of Maryland, OHCQ shall issue a license if at least one branch office is located within Maryland or the parent agency is located in a state bordering Maryland and either the:

(a) Bordering state has a reciprocal agreement for home health licensure, under which the agency may be inspected at the discretion of OHCQ; or

(b) Agency agrees to be inspected by OHCQ.

Transfer, Reassignment, and Voiding of License

The license may not be transferred or reassigned. The license shall be immediately void if the home health agency ceases to operate and shall be returned to OHCQ. COMAR 10.07.10.04.

A. General Information

Legal Facility Name:

Doing Business As or Trade Name:

FEIN Number:

Street Address:

City, State, Zip Code:
County:
Business Phone:
After Hours Emergency Phone:
Agency Email:
Fax Number:
Agency Website:
Name of Parent Agency if different from licensed agency:
Street Address of Parent Agency if different from licensed agency:
City, State, Zip Code of Parent Agency if different from licensed agency:
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
Name of Administrator:
Administrator's Business Email:
Administrator's Business Phone:
Patient Population Served: ☐ Adult ☐ Pediatric ☐ Maternal and Child Health ☐ Psychiatric ☐ Other:
Services: Select which services provided
☐Skilled Nursing: ☐ Direct ☐ Contract ☐ Direct and Contract If Contract is selected, please provide the name of the Contractor's Name:
☐Home Health Aides: ☐ Direct ☐ Contract ☐ Direct and Contract If Contract is selected, please provide the name of the Contractor's Name:
☐ Physical Therapy: ☐ Direct ☐ Contract ☐ Direct and Contract If Contract is selected, please provide the name of the Contractor's Name:

☐ Speech Language Pathology:
☐ Direct ☐ Contract ☐ Direct and Contract If Contract is selected, please provide the name of the Contractor's Name:

☐ Occupational Therapy:
☐ Direct ☐ Contract ☐ Direct and Contract If Contract is selected, please provide the name of the Contractor's Name:

☐ Medical Social Services:
☐ Direct ☐ Contract ☐ Direct and Contract If Contract is selected, please provide the name of the Contractor's Name:

☐ Infusion Services:
☐ Direct ☐ Contract ☐ Direct and Contract If Contract is selected, please provide the name of the Contractor's Name:

☐ Other Services**:** (List Other Services):
☐ Direct ☐ Contract ☐ Direct and Contract If Contract is selected, please provide the name of the Contractor's Name:

List all of the counties where the agency will provide services:

☐ Allegany	☐ Harford
☐ Anne Arundel	☐ Howard
☐ Baltimore City	☐ Kent
☐ Baltimore County	☐ Montgomery
☐ Calvert	☐ Prince George's
☐ Caroline	☐ Queen Anne's
☐ Carroll	☐ Somerset
☐ Cecil	☐ St. Mary's
☐ Charles	☐ Talbot
☐ Dorchester	☐ Washington
☐ Frederick	☐ Wicomico
☐ Garrett	☐ Worcester

C. Procedures

In the section below, list the name of the attached document that includes the specific procedure, as well as the page numbers.

Procedures for the administration of drugs and biologicals:

(a) The administration of treatment modalities, including any intravenous procedures, chemotherapy, parenteral feedings, and injections;

(b) The assurance of 24-hour-a-day availability of care for the hours during the administration of intravenous medications and nutritional support;

(c) The administration of drugs and treatments only by the following licensed agency staff:
(i) Physician,
(ii) Registered nurse, or
(iii) Licensed practical nurse if the drugs or treatments are administered under the supervision of a registered nurse in accordance with the physician's plan of treatment, and in accordance with a plan of care developed by a registered nurse;

(d) Minimum training in keeping with applicable law for staff who administer drugs and treatments;

(e) Drugs and treatments to be administered only as ordered by the physician;

(f) Documentation in the patient's medical record of medications administered and any medication errors, adverse drug reactions, and corrective actions;

(g) If the agency provides to any patient controlled drugs as described in Criminal Law Article, Title 5, Subtitle 4, Annotated Code of Maryland, written policies and procedures governing the disposal of controlled drugs in accordance with applicable federal and State laws and regulations.

Have services available at least 8 hours a day, 5 days a week, and available on an emergency basis 24 hours a day, 7 days a week by:
(a) Establishing a procedure by which any patient may contact a representative of the agency at any time by telephone;
(b) Ensuring that the person receiving patient calls is able to contact a registered nurse immediately, but not later than 1/2 hour after receipt of a patient's call; and
(c) Ensuring that the registered nurse: (i) Assesses the patient's needs; and (ii) In emergency situations, renders immediate care to the patient, or causes the patient to be treated by an appropriate health care provider.

D. Accreditation

Is the applicant requesting the accreditation organization or OHCQ conduct the initial federal certification survey? ☐ Accreditation Organization ☐ OHCQ
Accredited: ☐ Yes ☐ No
If yes, Name of Accreditation Organization:
Date of Accreditation:
Deemed Status? ☐ Yes ☐ No
If yes, Name of Deeming Agency:
Date of Deemed Status:

E. 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:
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 or agency 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 G.

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? ☐ Yes ☐ No If you answered yes, please list the name and type of facility in Section G.

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 G.

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 G.

5. Has the applicant or anyone with direct or indirect ownership interest in the agency been convicted of a felony? ☐ Yes ☐ No If you answered yes, please include the details of the conviction in Section G.

G. Additional Information

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

H. 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 agency 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 agency is in compliance with all applicable federal, State, and local laws and regulations.

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