

Maryland Department of Health
Office of Health Care Quality
Application for a Hospital License

Instructions

A person desiring to open a hospital, to continue the operation of an existing hospital, or to change the classification of an existing hospital shall file an application with the Office of Health Care Quality (OHCQ). Before a person may apply for a license to operate a hospital, 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 hospital has either received a certificate of need or is exempt from the certificate of need requirement.
2. Confirmation of online submission of the [Assurance of Compliance](#) to the Office for Civil Rights.
3. Health Insurance Benefit Agreement, [CMS Form 1561](#).
4. Documentation of accreditation (Award Letter and most recent full report) or evidence of application for accreditation, if applicable.
5. If the hospital plans to become certified, Novitas approval letter of CMS Form 855A.
6. 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.
7. 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 hospital; 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:**
 - 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 a hospital.
 - 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 a hospital.
- **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 10.05.01.04. 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.

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 Licenses

Separate licenses are required for institutions maintained on separate premises, even though both institutions are operated under the same management. [COMAR 10.07.01.06](#).

Separate licenses are not required for separate buildings on the same grounds. [COMAR 10.07.01.06](#).

A. General Information

Type of Application: Initial Change of Ownership

Legal Name of Hospital:

Doing Business As or Trade Name:

FEIN Number:

Street Address:

City, State, Zip Code:

County:

Hospital Business Phone:

After Hours Emergency Phone:

Fax Number:

Hospital Website:

Name of Hospital 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. Hospital Classification
Check the type of hospital classification from the list below and indicate the number of beds. COMAR 10.07.01.03B.
<input type="checkbox"/> Acute General
<input type="checkbox"/> Special – Psychiatric If checked, Number of beds:
<input type="checkbox"/> Special - Rehab If checked, Number of beds:
<input type="checkbox"/> Special - Children's If checked, Number of beds:
<input type="checkbox"/> Special - Chronic Disease If checked, Number of beds:
<input type="checkbox"/> Special - Communicable Disease If checked, Number of beds:
<input type="checkbox"/> Special - Orthopedics If checked, Number of beds:
<input type="checkbox"/> Special – Other If checked, Number of beds:
C. Accreditation
Does your facility plan to pursue accreditation? Yes No
If accredited or pursuing accreditation, select the accreditation organization below: <input type="checkbox"/> The Joint Commission <input type="checkbox"/> DNV
Accreditation Status: <input type="checkbox"/> Active <input type="checkbox"/> Inactive
If active, effective date:
If inactive, date of application:
Will the applicant request an initial federal certification survey from OHCQ or from the accreditation organization? <input type="checkbox"/> Accreditation Organization <input type="checkbox"/> OHCQ
Special Rehabilitation Hospitals Only: Accreditation through CARF is required
If CARF accredited, effective date:
If not accredited, date application submitted:
D. Ownership: Complete the section that is applicable
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: <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:
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:
<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:
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:
List the full name of every member of the Board of Directors.
Full Name of Board Member 1:
Full Name of Board Member 2:
Full Name of Board Member 3:
Full Name of Board Member 4:
Full Name of Board Member 5:
Full Name of Board Member 6:
Full Name of Board Member 7:
Full Name of Board Member 8:
Full Name of Board Member 9:
Full Name of Board Member 10:
E. Ownership of Property, Real Estate, and Equipment
COMAR 10.07.01.04 requires that ownership of property, real estate, and equipment shall be disclosed if it is other than the licensee's. If the licensee does not own the property, real estate, or equipment, disclose that information below. Attach additional pages, as needed.

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) or another CMS-designated State Survey Agency? 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 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 that relates to Medicaid or a nursing home? 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, I understand that 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 hospital 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 hospital is in compliance with all applicable federal, State, and local laws and regulations, including the administrative and procedural requirements in [COMAR 10.07.01](#) and the requirements of Health-General Article, Title 19, Subtitle 3.

I understand that in order to ensure the completion of any review or inspection by OHCQ of any major renovations, construction of patient care areas, or the establishment of a medical service as defined under [Health-General Article, §19-120](#), Annotated Code of Maryland, and not previously provided by the hospital, the hospital shall notify OHCQ 60 days before its occupancy or operation. [COMAR 10.07.01.04](#).

Sole Proprietorship: Applications on behalf of an individual owner must be signed by the individual.

Partnership, Corporation, Association, and Governmental Unit or Agency: Applications on behalf of a corporation, association, or governmental unit or agency shall be made by two officers of the corporation, association, or governmental unit or agency.

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: