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

Instructions

Applying for a License

The Office of Health Care Quality (OHCQ) licenses hospitals within correctional facilities (HCF). COMAR 10.07.12.04. The Office of Inmate Clinical Services at the Department of Public Safety and Correctional Services oversees other health care services within correctional facilities that do not house patients overnight.

The first step in obtaining a license for a hospital within a correctional facility 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. Synopsis of the health care program, a written document that includes:
    a. Number of beds
    b. Organization chart
    c. Description of care, treatment, and services provided for inmates
    d. Admission policies
    e. Discharge and referral policies and procedures
    f. Staffing patterns by shift
    g. Job classification and job descriptions of each employee
2. Copy of the medical service contract, if applicable
3. Written request for provision of surgical procedures, if applicable

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 HCF.
    - 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 an HCF.

- **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 Maryland Code Ann., Health General Article (HG) § 19-320 and COMAR 10.07.12.04. 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 Correctional Facility:
Doing Business As or Trade Name:
FEIN Number:
Legal Name of Medical Unit (if different than name of correctional facility):
Doing Business As or Trade Name of Medical Unit:
Street Address:
City, State, Zip Code:
County:
Business Phone:
After Hours Emergency Phone:
Fax Number:
Website:
Name of Warden (Administrative Head of Facility):
Title of Warden:
Business Email:
Warden'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. Medical Services
What services will the hospital provide? ☐ Medical ☐ Psychiatric
Name of Contact – Contractual Medical Services:
Title of Contact:
Business Email:
Business Phone:
C. 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 below.
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.
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
Is this 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:

D. 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 E.

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 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 health care facility been convicted of a felony that relates to Medicaid or nursing homes?
☐ Yes ☐ No If you answered yes, please include the details of the conviction in Section E.

6. Has the applicant for the health care facility violated Title 6.5 of the Maryland Code Ann., State Gov't Article? ☐ Yes ☐ No If you answered yes, please include the details of the violation 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, including Title 19, Subtitle 3 of the Health General Article, Maryland Code Ann. And orders as they apply to the use of facilities for health, welfare, and safety.
If the application is made on behalf of a corporation, association, or government agency, the signature of two officers of the organization is required below.

If the application is made on behalf of a corporation, association, or government agency, the signature of two officers of the organization is required below.
Print Full Name of Applicant 1:
Title of Applicant 1:
Signature of Applicant 1:
Date of Signature of Applicant 1:
Print Full Name of Applicant 2:
Title of Applicant 2:
Signature of Applicant 2:
Date of Signature of Applicant 2: