Maryland Department of Health
Office of Health Care Quality
Application for a General Hospice License

Instructions

Applying for a License

A person may not operate or represent itself as operating a general hospice care program in Maryland without first obtaining a license from the Office of Health Care Quality (OHCQ). Before a person may apply for a license to operate a general hospice care program, 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 hospice has either received a certificate of need or is exempt from the certificate of need requirement. COMAR 10.07.21.04.
2. Request for Certification in the Medicare Program, form CMS-417.
3. Confirmation of e-submission of Assurance of Compliance to the HHS Office of Civil Rights.
4. Health Insurance Benefit Agreement, form CMS-1561.
5. CMS Form 855A Approval Letter.
6. Written notice if the facility plans to use an accreditation organization for the initial federal certification survey.
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 hospice; 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 with Conditions:** Federal certification is required for a license without conditions. While federal certification is pending, the applicant will initially receive a license with conditions after all licensure requirements are met.
    - 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 hospice.
    - 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 hospice.
- **License without Conditions:** After the hospice is federally certified and all licensure requirements are met, a license without conditions will be issued.
- **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 10.07.21.04. 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

Type of Application: ☐ Initial ☐ Change of Ownership
Legal Name of Hospice:
Doing Business As or Trade Name:
FEIN Number:
Street Address of Principal Office:
City, State, Zip Code:
County:
Business Phone:
After Hours Emergency Phone:
Fax Number:
Website:

Business Email:
Name of Administrator:
Administrator's 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: Complete the section that is applicable

Select all of the counties that the hospice will provide services in:

☐ 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

Name of Medical Director:
Business Email:
Business Phone:
Does the agency plan to operate a hospice-owned inpatient unit? ☐ Yes ☐ No
If yes, how many beds? Beds
Inpatient Unit Phone:
Street Address of Inpatient Unit:
City, State, Zip Code of Inpatient Unit:
County of Inpatient Unit:
Hospice Does Not Own Inpatient Space: If the applicant proposes to operate a facility providing inpatient hospice care services and someone other than the applicant owns the building or real property, or both, list the name and address of the owner or owners below. If the hospice

owns the inpatient space, skip this section.
Name of Owner:
Street Address of Owner:
City, State, Zip Code of Owner:
County of Owner:
C. 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:
If yes, Date of Accreditation:
Deemed Status?: ☐ Yes ☐ No
If yes, Name of Deeming Agency:
If yes, Date of Deemed Status:
D. Ownership
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 5 percent or more of the applicant.
Name of Member 1:
Street Address for Member 1:
Phone Number for Member 1:
Name of Member 2:
Street Address for Member 2:
Phone Number for Member 2:
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:
Business Phone:
Business Fax:
Name of Resident Agent:
Street Address:
City, State, and Zip Code:
County:
Business Email:
Business Phone:
Business Fax:
Enter the full name, street address, city, state, zip code, and business phone number for each partner, owner, and investor directly or indirectly owning 5 percent or more of the applicant.
Name of Partner 1:
Title of Partner 1:
Street Address for Partner 1:
Name of Partner 2:
Title of Partner 2:
Street Address for Partner 2:

City, State, Zip Code for Partner 2:
Percent Owned for Partner 2:
Business Email for Partner 2:
Business Phone Number for Partner 2:
Business Fax Number for Partner 2:
Name of Partner 3:
Title of Partner 3:
Street Address for Partner 3:
City, State, Zip Code for Partner 3:
Percent Owned for Partner 3:
Business Email for Partner 3:
Business Phone Number for Partner 3:
Business Fax Number for Partner 3:
Name of Partner 4:
Title of Partner 4:
Street Address for Partner 4:
City, State, Zip Code for Partner 4:
Percent Owned for Partner 4:
Business Email for Partner 4:
Business Phone Number for Partner 4:
Business Fax Number for Partner 4:
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:
FEIN Number:
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:
County:
Business Email:
Business Phone:
Business Fax:
Name of Resident Agent:
Street Address:

City, State, Zip Code:
County:
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.
Name of Director:
Business Email of Director:
Street Address of Director:
City, State, Zip Code of Director:
Phone Number of Director:
Business Fax of Director:
Name of President:
Business Email of President:
Street Address of President:
City, State, Zip Code of President:
Phone Number of President:
Business Fax of President:
Percent Owned of President:
Name of Secretary:
Business Email of Secretary:
Street Address of Secretary:
City, State, Zip Code of Secretary:
Phone Number of Secretary:
Business Fax of Secretary:
Percent Owned of Secretary:
Full Name of Treasurer:
Business Email of Treasurer:
Street Address of Treasurer:
City, State, Zip Code of Treasurer:
Phone Number of Treasurer:
Business Fax of Treasurer:
Percent Owned 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 5 percent or more of the applicant.
Owner 1 Name:
Owner 1 Address:
Owner 1 Phone Number:
Owner 2 Name:

Owner 2 Address:
Owner 2 Phone Number:
Owner 3 Name:
Owner 3 Address:
Owner 3 Phone Number:
Owner 4 Name:
Owner 4 Address:
Owner 4 Phone Number:
Owner 5 Name:
Owner 5 Address:
Owner 5 Phone Number:

E. 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 F.

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 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 are answered yes, please include details of the conviction in Section F.

5. Has the applicant or anyone with direct or indirect ownership been convicted of a felony involving a nursing home or its residents? ☐ 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 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 applicant is in compliance with all applicable federal, State, and local laws and regulations, including the requirements of Health-General Article, Title 19, Annotated Code of Maryland, and COMAR 10.07.21.

The signature of an owner, member, partner, or officer is required below.
Print Full Name of Applicant 1:
Title of Applicant 1:
Signature of Applicant 1:
Date of Signature of Applicant 1: