

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

Instructions for Licensure

A "hospice house" means a residence operated by a Maryland licensed general hospice care program that provides home-based hospice services to hospice patients in a home-like environment and the care is not billed as general inpatient care. A person may not operate a hospice house without first obtaining a license from the Office of Health Care Quality (OHCQ) to operate a general hospice care program.

The first 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. 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.
2. 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.

OHCQ Determination of License Application

OHCQ will make one of the following determinations regarding your license application:

- **License Approval:** If the applicant meets all of the licensure requirements, OHCQ will issue a revised license to the general hospice that includes the authorized hospice house.
- **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 10.07.22.04](#) and [COMAR 10.07.21.03](#). 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.

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 survey.
2. OHCQ surveyors will conduct various tasks during the survey, such as a tour of the hospice house; interview of staff; and review of documentation.

A. General Information

This information relates to the hospice house.

Legal Name of Hospice Home:

Doing Business As or Trade Name:

FEIN Number:

Street Address:

City, State, Zip Code:

County:

Business Phone:

After Hours Emergency Phone:

Fax Number:

Website:

Business Email:

Name of Hospice House Manager:

Hospice House Manager's Business Email:

Hospice House Manager'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:

This information relates to the general hospice.

Legal Name of General Hospice:

Doing Business As or Trade Name of General Hospice:

License Number:

Name of Contact Person at the General Hospice:

Title of Contact Person:

Business Email of General Hospice Contact Person:

Business Phone of General Hospice Contact Person:

B. Ownership: Complete the section that is applicable

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

- | | |
|---|--|
| <input type="checkbox"/> Allegany | <input type="checkbox"/> Harford |
| <input type="checkbox"/> Anne Arundel | <input type="checkbox"/> Howard |
| <input type="checkbox"/> Baltimore City | <input type="checkbox"/> Kent |
| <input type="checkbox"/> Baltimore County | <input type="checkbox"/> Montgomery |
| <input type="checkbox"/> Calvert | <input type="checkbox"/> Prince George's |
| <input type="checkbox"/> Caroline | <input type="checkbox"/> Queen Anne's |
| <input type="checkbox"/> Carroll | <input type="checkbox"/> Somerset |
| <input type="checkbox"/> Cecil | <input type="checkbox"/> St. Mary's |
| <input type="checkbox"/> Charles | <input type="checkbox"/> Talbot |
| <input type="checkbox"/> Dorchester | <input type="checkbox"/> Washington |
| <input type="checkbox"/> Frederick | <input type="checkbox"/> Wicomico |
| <input type="checkbox"/> Garrett | <input type="checkbox"/> Worcester |

Will the owners of the general hospice also own the hospice house? Yes No If you answered no, please explain in Section D.

C. 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 D.

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 D.

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 D.

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 D.

5. Has the applicant or anyone with direct or indirect ownership interest in the agency 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 D.

D. Additional Information

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

E. 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 this applicant 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, [COMAR 10.07.22.04](#) 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: