# Maryland Department of Health
# Office of Health Care Quality
# Application for Limited Private Inpatient Facility License

## Instructions

### Applying for a License

Prior to operating a limited private inpatient facility (LPIF) in Maryland, the facility must first obtain a limited private inpatient facility license from the Office of Health Care Quality (OHCQ). The first step in applying for a license is to complete this application. The application must be typed. Handwritten applications 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.

The license is not transferable to another owner or a new location. A separate license is required for facilities maintained on separate premises. If a licensee's ownership is being changed or a relocation is being planned, the licensee must apply for a new license by completing this application.

**Required Attachments:**

1. Fire, liability, and hazard insurance coverage on the building the facility occupies.
2. Copy of Zoning Permit from local jurisdiction.
3. Copy of Use and Occupancy Permit from local jurisdiction.
4. Copy of the fire inspection report.
5. Copy of Food Service Permit from local jurisdiction.
6. Facility Service Plan as described in COMAR 10.07.16.10.
7. Documentation from the Joint Commission of current accreditation (award letter and most recent full report) or confirmation of submitted application for accreditation.
8. Letter of Good Standing: The applicant must obtain an official letter of good standing from the Maryland Department of Assessments and Taxation (SDAT)'s 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 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:

- **Provisional License: If the applicant is not yet accredited by The Joint Commission:**
  - If there are If there are no deficiencies on the survey, you will receive a written report called a Notice of Compliance and a one-year Provisional License to operate a limited private inpatient facility. If the facility is not accredited within one year following the issuance of the provisional license, the provisional license will expire and the facility must cease operations. COMAR 10.07.16.06.
  - 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 one-year **Provisional License** to operate a limited private inpatient facility.
- **Non-Expiring License:**
  - If the facility is not accredited in one year, the provisional license will expire and the facility must cease operations. COMAR 10.07.16.06.
  - Upon successful accreditation, a licensed LPIF shall submit proof of accreditation to OHCQ.
  - After OHCQ verifies the facility's accreditation, a Non-Expiring License 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 the Department has received all of the required application materials. 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

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| Type of Applications: ☐ Initial | ☐ Change of Ownership | ☐ Relocation |
| Legal Name of Facility: | | |
| Doing Business As or Trade Name: | | |

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| FEIN Number: |
| Street Address: |
| City, State, Zip Code: |
| County: |
| Business Phone: |
| After Hours Emergency Phone: |
| Business Email: |
| Fax Number: |
| Facility's Website: |
| Name of Administrator: |
| Business Email: |
| Administrator's Business Phone: |
| Name of Clinical Director: |
| Clinical Director's Business Email: |
| Clinical Director'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. Description of Services** |
| How many beds are you requesting: beds |
| Provide a brief description of the services that the applicant will provide: |

| C. Accreditation |
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| Is the applicant currently accredited by The Joint Commission?: ☐ Yes ☐ No |
| If yes, what is the effective date of accreditation? |
| If no, what is the date the application was submitted to the Joint Commission? |
| **D. 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: |

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| 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, 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:<br>☐ Stock Corporation ☐ Tax Exempt Nonstock Corporation ☐ Close Corporation |

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| 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: |
| 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: |

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| 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: |
| If this application is filed on behalf of a corporation, association, or governmental unit or agency, list the ownership of property, real estate, and equipment, if other than the applicant's. See COMAR 10.07.16.05C(2). |
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## 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 interest in the agency been convicted of a felony that relates to Medicaid or Medicare or a crime involving moral turpitude? ☐ 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 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 applicant is in compliance with all applicable federal, State, and local laws and regulations, including the State administrative and procedural requirements governing limited private inpatient facilities in COMAR 10.07.16.

I understand that in the event of the loss of accreditation and the conclusion of all appeals to the Joint Commission, the facility will promptly arrange for the safe discharge of each resident to another facility or to appropriate outpatient services. The facility shall cease operation upon the discharge of all residents. COMAR 10.07.16.05.

Corporation, Association, or Governmental Agencies: An application filed 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. The signatures of two officers are required below.

Sole Proprietorships, LLC, and Partnerships: The signature of an owner, member, or partner, is required below.

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| 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: |