Maryland Department of Health
Office of Health Care Quality
Application for a Residential Service Agency License

Instructions

A person, partnership, corporation, association, or other entity may not conduct or operate a residential service agency (RSA) in Maryland without first obtaining a license from the Office of Health Care Quality (OHCQ) and complying with the regulations in COMAR 10.07.05. The first step in the licensure process is to complete this application. The application must be typed. Handwritten applications are not accepted and will be returned to the applicant. Submit this 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.

Completion of the RSA Certification:
An individual with authority over the RSA's pay or employment practices must complete an on-line RSA Certification form related to worker classification of personal care aides. This is a requirement for all RSA applicants, including those that do not plan to hire personal care aides. Additional information related to this requirement is located on the OHCQ website.

Required Attachments:

1. Business Plan: Must demonstrate the financial or administrative ability to operate an RSA in compliance with this chapter. COMAR 10.07.05.04A(2)h. It must include:
    a. A 1-year operating budget
    b. A marketing plan that identifies the populations to be served
    c. A detailed and specific description of agency services.
2. Organizational chart.
3. Policies and procedures as specified in COMAR 10.07.05.08B, including administration, personnel, patient care, informed consent, and environment and safety. See Section B, Home Health Care Services.
4. 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.
5. 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.

Determination of the Request for a License

Once all of the required application materials are submitted, OHCQ will make one of the following determinations regarding your license application:

1. **License Approval:** After OHCQ determines that the applicant is in compliance with all licensure requirements, a license is issued to the applicant. The license approval may be with or without conditions.

2. **License Denial:** If the applicant is unable to comply with all of the licensure requirements, then the application will be denied. If the application is denied, the applicant will receive a detailed letter explaining the reason for the denial and the appeal rights.

3. **License Application Administratively Closed:** An application is not complete until the Department has received all the materials required in this application. 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.

4. **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.

Change of Ownership

Whenever ownership of an agency is transferred from the person or organization named on the license to another person or organization, the future owner shall apply for a new license. The Department shall issue a new license to a new owner who meets the requirements for licensure under this chapter. See COMAR 10.07.05.05.

New Home Health Care Services

If a licensed RSA is adding a new home health care service, the RSA must complete this initial licensure application and submit it along with all required attachments to OHCQ, including any policies or procedures related to the new service.

A. General Information

Type of Application: ☐ Initial ☐ Change of Ownership ☐ New Service
Legal Name of RSA:
Doing Business As or Trade Name:
FEIN Number:
Street Address:
City, State, Zip Code:
County:
Primary Business Phone:
After Hours Emergency Phone Number:
Fax Number:
RSA Business Email:
RSA Website:

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. Home Health Care Services
List the normal business hours below:
Monday:
Tuesday:
Wednesday:
Thursday:
Friday:
Saturday:
Sunday:

Select all of the services that the applicant will be providing. Note that a home health agency provides skilled nursing services, home health aide services, and at least one other home health care service, that are centrally administered. If the applicant has questions about the difference between an RSA and a home health agency, please contact the RSA Team for more information.

Home health care services:

☐ Nursing
☐ Home health aide
☐ Physical therapy
☐ Occupational therapy
☐ Speech therapy
☐ Audiology
☐ Respiratory therapy
☐ Medical social services
☐ Dietary and nutritional services
☐ Durable medical equipment: Delivery, installation, maintenance, or replacement of, or instruction in the use of, medical equipment

Invasive medical equipment is a device that invades tissue or a body cavity to maintain treatment modalities, such as intravenous lines, enteral or parenteral; catheters; ventilators; gastric or nasogastric tubes; tracheostomy; and ostomies.

Will the agency provide invasive medical equipment or supplies? ☐ Yes ☐ No

If the agency will provide invasive medical equipment or supplies, is there currently a 24-hour-a-day maintenance or service agreement in place in case of equipment failure? ☐ Yes ☐ No

Is the agency accredited? ☐ Yes ☐ No

If yes, Name of Accreditation Organization:

Date of Accreditation:

What population will you serve?

☐ Adults ☐ Children (less than 18 years old) ☐ Adult and children

Policies and Procedures

Waiver of a Specific Policy or Procedure: To request that OHCQ waive the requirement for a specific policy or procedure that is specified in COMAR 10.07.05.08B, list the specific policy or procedure below and explain why it is inappropriate or unnecessary for this RSA.

In the section below, list the name of the attached document that includes the specific policy or procedure, as well as the page numbers. If you have requested a waiver above for a certain policy or procedure, enter N/A.

Administration

Scope of services:

Delineation of services provided by the agency when the agency coordinates care within the agency or with another provider:

Notification to the client or client representative with legal authority to make health care decisions of the agency's responsibilities to coordinate care when appropriate:
Admission criteria:
Assessment of potential clients before their acceptance into the program:
Billing and service records, maintenance of charges, and similar items, except for those clients receiving services through a managed-care health benefits plan or third-party payor, in which case records are maintained as required by the third-party payor:
Quality assurance program:
Clinical management, including assessment, plans, delegation, and supervision:
Personnel
Job descriptions and educational qualifications for all employees and contractors:
Skill assessments of all employees and contractors:
Health requirements for employees and contractors:
Patient Care
Provision of home health care services and criteria for determining the need for skilled services:

Administration of drugs:
Enteral and parenteral nutrition procedures:
Frequency of client monitoring:
Training and retraining of clients or their family members, when indicated:
Informed Consent
A client or client representative with legal authority to make legal decisions, signs an informed consent form consenting to changes to the agency’s recommended plan of care; or:
A client signs an informed consent form consenting to assistance by a nonlicensed individual with treatments of a routine nature, or with the self-administration of medications:
Environment and Safety
Preparation and storage of enteral formulas, intravenous therapies, other supplies, equipment, and similar items:
Infection control procedures:
Disposal of biomedical waste:
Maintenance of equipment; and procedures:
Emergency:

C. Branch Offices: Complete this section only if applicant has branch offices

A branch office is a satellite office of a residential service agency that is operated by the same person, corporation, or other business entity that manages the parent RSA. The branch office has the same ownership tax identification number, upper-level management, and policies and procedures as the parent RSA. The branch office operates in the same geographic area served by the parent RSA. A branch office may operate under the same license of an RSA. List each branch office below. See COMAR 10.07.05.02B(3) and COMAR10.07.05.03.
Name of Branch Office 1:
Business Phone Number:
Street Address of Branch Office 1:
City, State, and Zip Code of Branch Office 1:
County of Branch Office 1:
Does it have the same hours as the main office? ☐ Yes ☐ No If no, what are the hours?
Name of Branch Office 2:
Business Phone Number of Branch Office 2:
Street Address of Branch Office 2:
City, State, and Zip Code of Branch Office 2:
County of Branch Office 2:
Does it have the same hours as the main office? ☐ Yes ☐ No If no, what are the hours?
Name of Branch Office 3:
Business Phone Number:
Street Address of Branch Office 3:
City, State, and Zip Code of Branch Office 3:
County of Branch Office 3:
Does it have the same hours as the main office? ☐ Yes ☐ No If no, what are the hours?

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 25 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: ☐ Limited ☐ General
Name of Partnership:
Street Address of Principal Office:
City, State, and Zip Code:
Business Email of Principal Office:
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 25 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: ☐ Stock Corporation ☐ Tax Exempt Nonstock Corporation ☐ Close Corporation
Type of 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:
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:

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 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? ☐ Yes ☐ No If you answered yes, please include the details of the conviction in Section F.

6. Does the applicant hold any license or certification under the Health Occupations Article or Health-General Article, Annotated Code of Maryland? ☐ Yes ☐ No If you answered yes, please include the details of the license or certification in Section F.

7. Does the applicant have any criminal charges or convictions, and disclosure of any findings of violation of Medicare and Medicaid laws and regulations; Health-General Article, Annotated Code of Maryland; or Health Occupations Article, Annotated Code of Maryland? ☐ Yes ☐ No If you answered yes, please include the details of the criminal charges or convictions in Section F.

8. Does the applicant have any prior denial, suspension, or revocation of a license or certification to provide care to third parties? Yes ☐ No If you answered yes, please include the details of the criminal charges or convictions 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 this applicant is in compliance with all applicable federal, State, and local laws and regulations, including the State administrative and procedural requirements governing residential service agencies in COMAR 10.07.05.

I hereby swear and affirm that I am at least 21 years of age and I am otherwise competent to sign this affidavit.

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