

**Maryland Department of Health**  
**Office of Health Care Quality**  
**Application for a Residential Treatment Center License**

**Instructions**

**Applying for a License**

A person may not establish, conduct, maintain, or operate a residential treatment center (RTC) 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 an RTC, 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 §19–319](#).

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. The State Health Plan for Facilities and Services: Residential Treatment Centers, which is incorporated by reference, can be found at [COMAR 10.24.07.01](#).

**Required Attachments:**

1. Submit documentation that the Maryland Health Care Commission has determined that the RTC has either received a certificate of need or is exempt from the certificate of need requirement.
2. Written permission from the local zoning authority for an original license in municipalities which have established zoning.
3. Written approval from the appropriate fire authorities.
4. Food service permit.
5. Signed agreement between the center and the principal somatic physician.
6. Signed agreement between the center and the psychiatrist.
7. Evidence of current accreditation, including a copy of the current accreditation letter issued to the center, a copy of the standards determined not to be in compliance, or with recommendations for improvement issued to the center; and the evidence of the action taken to correct noncompliance which was submitted to the accreditation organization.
8. Documentation that the child care services and program are approved by the Department of Human Services.
9. Documentation that the educational program is approved by the Maryland State Department of Education.
10. 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.
11. 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](mailto:wccinsur@wcc.state.md.us).

### **On-site Licensure Survey and Conditional License**

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 center; interview of staff; and review of documentation.

### **OHCQ Determination of License Application**

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

- **If accreditation by The Joint Commission is pending:**
  - o If there are no deficiencies on the survey, you will receive a written report called a Notice of Compliance and a **Provisional License** to operate an RTC.
  - o If there are deficiencies, you will receive a Statement of Deficiencies. You have 10 business days to submit 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 **Provisional License** to operate an RTC.
  - o After the RTC is accredited by The Joint Commission, a **Non-Expiring License** will be issued.
- **If the applicant is accredited by The Joint Commission:**
  - o If there are no deficiencies on the survey, you will receive a written report called a Notice of Compliance and a **Non-Expiring License** to operate an RTC.
  - o If there are deficiencies, you will receive a Statement of Deficiencies. You have 10 business days to submit 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 **Non-Expiring License** to operate an RTC.
- **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 the materials required under COMAR 10.07.04.04. 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.

<b>Separate License Required</b>
Centers maintained on separate premises shall obtain separate licenses, even though operated under the same management. <a href="#">COMAR 10.07.04.03.</a>
<b>Submission of Plans</b>
Prior to making improvements or performing work that would alter the Center’s functional structure or approved bed capacity, all related construction plans must be submitted to the Secretary of Health. These plans shall have the prior approval of local zoning authorities and the appropriate fire authorities.
The Secretary shall promptly review the plans and shall notify the applicant or licensee within 30 days that the building, alteration, additions, or changes, are approved or disapproved with any recommendations that the Secretary may make. If an application is disapproved, the applicant or licensee shall be informed of the reasons at the time of notification. <a href="#">COMAR 10.07.04.07.</a>
<b>A. General Information</b>
Legal Name of RTC:
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:
Business Email:
Website:
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>B. Services</b>
What is the requested number of beds?                      beds
Name of Principal Somatic Physician:
Business Email:



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:
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:
<b>Partnership - Skip this section if applicant is not a partnership</b>
Type of Partnership: <input type="checkbox"/> Limited <input type="checkbox"/> 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:
<b>Corporation, if applicable</b>
Type of Corporation: <input type="checkbox"/> Stock Corporation <input type="checkbox"/> Tax Exempt Nonstock Corporation <input type="checkbox"/> Close Corporation
Is this Corporation: <input type="checkbox"/> For Profit <input type="checkbox"/> Non-Profit
Date of Charter:
Date of Articles of Incorporation:
<b>Non-Maryland Corporation:</b> 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 for 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 of Owner 2:
Phone Number of Owner 2:
Full Name of Owner 3:
Street Address of Owner 3:
Phone Number of Owner 3:
Full Name of Owner 4:
Street Address of Owner 4:
Phone Number of Owner 4:
Full Name of Owner 5:
Street Address of Owner 5:
Phone Number of Owner 5:
<b>D. Disclosures</b>
<p>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.</p> <p>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.</p>

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 answered yes, please list the name and type of license in Section E.

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 to a nursing home?    Yes    No    If you answered yes, please list the name and type of license 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 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 administrative and procedural requirements in COMAR 10.07.04.03 and all disclosure requirements as set forth in Health-General Article, Title 19, Subtitle 3, Annotated Code of Maryland; and any regulation adopted under Health-General Article, Title 19, Subtitle 3, Annotated Code of Maryland, including this chapter.

I understand that a license shall be valid only in the hands of the licensee to whom it is issued and may not be subject to sale, assignment, or other transfer, voluntary or involuntary, nor may a license be valid for any premises other than those for which originally issued.

Corporations and Governmental Agencies: Application on behalf of a corporation or association or a governmental unit or agency shall be made by two of its officers. The signature of two officers is required below.

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

Print Full Name of Applicant 1:

Title of Applicant 1:

Signature of Applicant 1:

Date:

Print Full Name of Applicant 2:

Title of Applicant 2:

Signature of Applicant 2:

Date: