

**Maryland Department of Health  
Office of Health Care Quality  
Application for Health Care Staff Agency License**

**Instructions for Initial License Application**

**Submitting a Request for an Initial License**

Prior to operating a health care staff agency in Maryland, the agency must first obtain a health care staff agency license from the Office of Health Care Quality (OHCQ). A person operating an agency may not use the term “health care staff agency” in its advertising without first obtaining a license from OHCQ. See [COMAR 10.07.03.04](#).

To apply for a license, 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 online system link on the [OHCQ website](#). There is no fee to apply for a license.

**Required Attachments:**

1. Policies and procedures as required in [COMAR 10.07.03.08](#).
2. Letter of Good Standing: The applicant must obtain an official letter of good standing from the [Maryland’s Department of State 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.
3. Workers’ Compensation: Attach a copy of your 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).

**Change of Ownership**

A license is valid only in the name of the licensee to whom the license is issued and is not subject to sale, assignment, or other transfer. [COMAR 10.07.03.04](#). If the ownership is changing, the new owner must submit an initial license application and receive a new license prior to operating the agency.

**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:

- **License Approval:** After OHCQ determines that the applicant is in compliance with all licensure requirements, a license is generally issued within 1 to 2 weeks.

- **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 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 and submit a new application in the future.

At any time, an applicant may withdraw an application for a license by notifying OHCQ in writing. An applicant who withdraws an application may reapply by submitting a new application at any time in the future.

### A. General Information

Type of Application: <input type="checkbox"/> Initial <input type="checkbox"/> Change of Ownership				
Legal Name of Business		Doing Business As or Trade Name		
Street Address			FEIN Number	
City	State	Zip Code	County	
Business Phone	After Hours Emergency Phone		Fax Number	
Agency Email	Agency Website			
Name of Primary Contact for Application		Title of Primary Contact		
Business Email		Business Phone	Alternate Phone	
Name of Secondary Contact for Application		Title of Secondary Contact		
Business Email		Business Phone	Alternate Phone	

### B. Description of Services

What type of services will the applicant provide?

<b>C. Ownership: Complete the section that is applicable</b>				
<b>Sole Proprietorship - Skip this section if applicant is not a sole proprietorship</b>				
Name of Sole Proprietor			Title	
Street Address				
City		State	Zip Code	County
Business Email			Business Phone	Business Fax
<b>Limited Liability Company (LLC) - Skip this section if applicant is not a limited liability company</b>				
<b>Non-Maryland LLC:</b> If this is a limited liability company 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, state where the LLC was formed.				
Name of Limited Liability Company				
Street Address of Principal Office				
City		State	Zip Code	County
Business Email of Principal Office			Business Phone	Business Fax
Name of Resident Agent			Title	
Street Address				
City		State	Zip Code	County
Business Email			Business Phone	Business Fax
<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	Zip Code	County
Business Email of Principal Office			Business Phone	Business Fax

Name of Resident Agent (Limited Partnership) or Name of Partner 1 (General Partnership)		Title	
Street Address			
City	State	Zip Code	Percent Owned
Business Email		Business Phone	Business Fax
<b>Corporation - Skip this section if applicant is not a corporation</b>			
Type: _____ Stock Corporation    _____ Nonstock Corporation    _____ Close Corporation			
Is this corporation    _____ For Profit    _____ Non-Profit			
Date of Charter	Date of Articles of Incorporation	FEIN Number	
<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, state where corporation was formed.			
Name of Corporation			
Street Address of Principal Office			
City	State	Zip Code	County
Business Email of Principal Office		Business Phone	Business Fax
Name of Resident Agent		Title	Percent Owned
Street Address			
City	State	Zip Code	County
Business Email		Business Phone	Business Fax
<b>D. Disclosures</b>			
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.			

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.
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 include details of the conviction in Section E.
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 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 OHCQ shall be notified of any change in agency ownership, name, or address within 30 calendar days of the change; that I understand that any change in agency ownership, name, or address requires the issuance of a new license; and that I am aware that OHCQ may impose a fine of \$100 if the above notification does not occur within 30 calendar days of the change.

I certify that this agency is in compliance with all applicable federal, State, and local laws and regulations, including the administrative and procedural requirements in [COMAR 10.07.03](#).

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.

The signature of each applicant is required below.

Signature of Applicant 1		Date
Full Name of Applicant 1	Title of Applicant 1	
Signature of Applicant 2		Date
Full Name of Applicant 2	Title of Applicant 2	
Signature of Applicant 3		Date
Full Name of Applicant 3	Title of Applicant 3	