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

Instructions for Initial Licensure

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 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. See 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'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.
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:

- **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. The license may be with or without conditions.
- **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.
- **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.

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
Street Address	

City	State (Select One	Zip Code	County (Select One)
Primary Business Phone	After Hours Emergency Phone	Fax Number	
RSA Business Email	FEIN Number		

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
From:							
To:							

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 OHCQ 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 COMAR 10.07.05.08B

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	**Name of Attachment and Page Numbers**
○ 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	**Name of Attachment and Page Numbers**
○ 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	**Name of Attachment and Page Numbers**
○ 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	**Name of Attachment and Page Numbers**
○ 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	**Name of Attachment and Page Numbers**
○ 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 10.07.05.03.

Name of Branch Office 1			Business Phone Number
Street Address of Branch Office 1			
City	State (Select One	Zip Code	County (Select One)
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
Street Address of Branch Office 2			
City	State (Select One	Zip Code	County (Select One)
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 (Select One	Zip Code	County (Select One)
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 (Select One	Zip Code	County (Select One)
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 a limited liability company formed in a State or territory outside the State 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 (Select One	Zip Code	County (Select One)
Business Email of Principal Office		Business Phone	Business Fax
Name of Resident Agent		Title	
Street Address			
City	State (Select One	Zip Code	County (Select One)
Business Email		Business Phone	Business Fax
Name of Member 1		Business Email of Member 1	
Street Address			
City	State (Select One	Zip Code	Business Phone
Name of Member 2		Business Email of Member 2	
Street Address			
City	State (Select One	Zip Code	Business Phone
Name of Member 3		Business Email of Member 3	
Street Address			
City	State (Select One	Zip Code	Business Phone
If there are additional members, provide the information in Section F.			
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 (Select One	Zip Code	County (Select One)	
Business Email of Principal Office		Business Phone	Business Fax	
Name of Resident Agent (Limited Partnership) or Name of Partner 1 (General Partnership)		Title		Percent Owned
Street Address				
City	State (Select One	Zip Code	County (Select One)	
Business Email		Business Phone	Business Fax	
Below list all partners owning more than 25 percent of the applicant.				
Name of Partner 2		Title of Partner 2		
Street Address				
City		State (Select One)	Zip Code	Percent Owned
Business Email		Business Phone	Business Fax	
Name of Partner 3		Title of Partner 3		
Street Address				
City		State (Select One)	Zip Code	Percent Owned
Business Email		Business Phone	Business Fax	
Corporation - Skip this section if applicant is not a corporation				
Type: ☐ Stock Corporation ☐ Nonstock Corporation ☐ Close Corporation				
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, state where the corporation was formed.			
Name of Corporation			
Street Address of Principal Office			
City	State (Select One)	Zip Code	County (Select One)
Business Email of Principal Office		Business Phone	Business Fax
Name of Resident Agent		Title	
Street Address			
City	State (Select One)	Zip Code	Percent Owned
Business Email		Business Phone	Business Fax
Director		Business Email of Director	
Street Address			
City		State (Select One)	Zip Code
Business Email		Business Phone	Business Fax
President		Business Email of President	
Street Address			
City		State (Select One)	Zip Code / Percent Owned
Business Email		Business Phone	Business Fax
Secretary		Business Email of Secretary	
Street Address			
City		State (Select One)	Zip Code / Percent Owned
Business Email		Business Phone	Business Fax
Treasurer		Business Email of Treasurer	

Street Address		
City	State (Select One)	Zip Code
Business Email	Business Phone	Business Fax

List the full name and address of any individual or corporate owner with 25 percent or more interest in the applicant.

Full Name **Street Address, City, State, and Zip Code**

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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 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.

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 residential service agency 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 understand that the license shall be conspicuously posted at the facility.

I hereby swear and affirm that I am over the age of 21 and I am otherwise competent to sign this affidavit.

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