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

Instructions

Applying for License

A person, partnership, corporation, or association, or any State or local government or agency thereof, may not conduct, operate, or maintain a home health agency in Maryland without being licensed by the Office of Health Care Quality (OHCQ). Before a person may apply for a license to operate a home health agency, 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 §19–114(b).

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.

Required Attachments:

1. Documentation that the Maryland Health Care Commission has determined that the home health agency has either received a certificate of need or is exempt from the certificate of need requirement. COMAR 10.24.01
2. List of the names of those that serve on the Professional Advisory Group.
3. Civil Rights Information Request.
4. Proof of accreditation (award letter and the most recent full survey report) or proof of application for accreditation.
5. Written notice if the facility plans to use an accreditation organization for the initial federal certification survey.
6. Procedures listed in COMAR 10.07.10.04.
7. Attach a copy of the declaration page from your general liability insurance coverage.
8. 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.
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 agency; interview of staff; and review of documentation.

OHCQ Determination of License Application

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

- **License Approval:** If there are no deficiencies on the survey, you will receive a written report called a Notice of Compliance and a license to operate a home health agency. 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 license to operate a home health agency.
    - **Provisional License:** In certain circumstances, OHCQ may issue a provisional license. COMAR 10.07.10.06.
- **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 OHCQ has received all the materials required under COMAR 10.07.10.04. 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.

Parent Agency Outside of Maryland

Per COMAR 10.07.10.04, if a parent agency is located outside of Maryland, OHCQ shall issue a license if at least one branch office is located within Maryland or the parent agency is located in a state bordering Maryland and either the:

(a) Bordering state has a reciprocal agreement for home health licensure, under which the agency may be inspected at the discretion of OHCQ; or
(b) Agency agrees to be inspected by OHCQ.

Transfer, Reassignment, and Voiding of License

The license may not be transferred or reassigned. The license shall be immediately void if the home health agency ceases to operate and shall be returned to OHCQ. COMAR 10.07.10.04.

A. General Information

Legal Facility Name	
Doing Business As or Trade Name	FEIN Number

Street Address			
City	State (Select One)	Zip Code	Countv (Select One)
Primary Agency Phone	After Hours Emergency Phone		Fax Number
Agency Email	Agency Website		
Name of Parent Agency if different from licensed agency			
Street Address of Parent Agency if different from licensed agency			
City	State (Select One)	Zip Code	
Name of Primary Contact for Application	Title of Primary Contact		
Business Email	Business Phone		
Name of Secondary Contact for Application	Title of Secondary Contact		
Business Email	Business Phone		

B. Services

Name of Administrator	Business Email	Business Phone

Patient Populations Served:
___ Adult ___ Pediatric ___ Maternal and Child Health ___ Psychiatric
___ Other: _____

Services	Direct	Contract	Direct and Contract	Contractor's Name
Skilled Nursing				
Home Health Aides				
Physical Therapy				
Speech Language Pathology				
Occupational Therapy				
Medical Social Services				
Infusion Services				
List Other Services				

List all of the counties where the agency will provide services:			
__ Allegany __ Anne Arundel __ Baltimore City __ Baltimore County __ Calvert __ Caroline	__ Carroll __ Cecil __ Charles __ Dorchester __ Frederick __ Garrett	__ Harford __ Howard __ Kent __ Montgomery __ Prince George's __ Queen Anne's	__ Somerset __ St. Mary's __ Talbot __ Washington __ Wicomico __ Worcester

C. Procedures

In the section below, list the name of the attached document that includes the specific procedure, as well as the page numbers.

Procedures for the administration of drugs and biologicals:	**Name of Attachment and Page Numbers**
(a) The administration of treatment modalities, including any intravenous procedures, chemotherapy, parenteral feedings, and injections;	
(b) The assurance of 24-hour-a-day availability of care for the hours during the administration of intravenous medications and nutritional support;	
(c) The administration of drugs and treatments only by the following licensed agency staff: (i) Physician, (ii) Registered nurse, or (iii) Licensed practical nurse if the drugs or treatments are administered under the supervision of a registered nurse in accordance with the physician's plan of treatment, and in accordance with a plan of care developed by a registered nurse;	
(d) Minimum training in keeping with applicable law for staff who administer drugs and treatments;	
(e) Drugs and treatments to be administered only as ordered by the physician;	
(f) Documentation in the patient's medical record of medications administered and any medication errors, adverse drug reactions, and corrective actions;	
(g) If the agency provides to any patient controlled drugs as described in Criminal Law Article, Title 5, Subtitle 4, Annotated Code of Maryland, written policies and procedures governing the disposal of controlled drugs in accordance with applicable federal and State laws and regulations.	

Have services available at least 8 hours a day, 5 days a week, and available on an emergency basis 24 hours a day, 7 days a week by:	**Name of Attachment and Page Numbers**
(a) Establishing a procedure by which any patient may contact a representative of the agency at any time by telephone;	
(b) Ensuring that the person receiving patient calls is able to contact a registered nurse immediately, but not later than 1/2 hour after receipt of a patient's call; and	
(c) Ensuring that the registered nurse: (i) Assesses the patient's needs; and (ii) In emergency situations, renders immediate care to the patient, or causes the patient to be treated by an appropriate health care provider.	

D. Accreditation

Is the applicant requesting the accreditation organization or OHCQ conduct the initial federal certification survey? Accreditation Organization_____ OHCQ_____

Accredited: Yes_____ No_____	If yes, Name of Accreditation Organization	Date of Accreditation
Deemed Status? Yes_____ No_____	If yes, Name of Deeming Agency	Date of Deemed Status

E. 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
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 (Select One)	Zip Code
Business Email of Principal Office	Business Phone	Business Fax
Name of Resident Agent		

Street Address		
City	State (Select One)	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	Street Address	Phone Number

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
Business Email of Principal Office	Business Phone	Business Fax
Name of Resident Agent		
Street Address		
City	State (Select One)	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, and investor directly or indirectly owning 2 percent or more of the applicant.

Full Name	Street Address	Phone Number

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 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

Business Email of Principal Office	Business Phone	Business Fax

Name of Resident Agent

Street Address

City	State (Select One)	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 Street Address Phone Number

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 Street Address Phone Number

F. 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 G.

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 G.

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 G.

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 G.

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 G.

G. Additional Information

Use this space to clarify any of your previous responses. Attach additional sheets, as needed.

H. 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 agency is in compliance with all applicable federal, State, and local laws and regulations.

The signature of an owner, member, partner, or officer is required below.

Full Name of Applicant	Title of Applicant
Signature of Applicant	Date