

**Office of Health Care Quality  
Nursing Home  
Change of Ownership (CHOW) Application**

**Instructions**

**Applying for a Change in Ownership of a Nursing Home**

A nursing home is defined under Maryland law as a comprehensive care or extended care facility that offers nonacute inpatient care to patients suffering from a disease, chronic illness, condition, disability of advanced age, or terminal disease requiring maximal nursing care without continuous hospital services and who require medical services and nursing services rendered by or under the supervision of a licensed nurse together with convalescent, restorative, or rehabilitative services.

A person may not establish, operate, or continue the operation of an existing comprehensive care facility or extended care facility without first obtaining a license from the Office of Health Care Quality (OHCQ). See [COMAR 10.07.02.03A](#).

Complete this form to initiate the license application process. The application must be typed. Handwritten applications are not accepted and will be returned to the applicant. Submit this completed application and all of the required attachments electronically through the [Long Term Care Ownership Dashboard](#). There is no fee to apply for a license.

**Required Attachments**

**Forms:**

1. 39-460F Nursing Home CHOW Application
2. 39-461F Nursing Home Ownership
3. 39-462F Ownership of Property
4. 39-463F Disclosure Form
5. 39-464F Director of Nursing Agreement
6. 39-465F Medical Director Agreement
7. [CMS Form 671 Long Term Care Facility Application for Medicare and Medicaid](#).
8. [CMS Form 1561](#), Health Insurance Benefit Agreement.

**Local Permits:** submit a copy if the permit is required by the local jurisdiction

1. Kitchen permit.
2. Zoning permit.
3. Use and occupancy permit.
4. Fire inspection report.

**Documents:** submit a copy of the following documents

1. Documentation from the Maryland Health Care Commission (MHCC) of a determination that the applicant has either received a certificate of need or is exempt from the certificate of need requirement.
2. Confirmation of online submission of the [Assurance of Compliance](#) to the Office for

Civil Rights.

3. Agreement between the Director of Nursing and the nursing home.
4. Policies and procedures, [COMAR 10.07.02.13](#) and [COMAR 10.07.09.15](#).
5. Quality assurance plan, [COMAR 10.07.02.64](#).
6. Resident agreement. A [sample resident agreement](#) is on the OHCQ website.
7. Transfer agreement with a local hospital, [COMAR 10.07.02.39](#).
8. Documentation for continued operation of a special care unit, if applicable
9. [Evidence of Financial Ability to Operate](#). The information may be submitted in an alternative format. Financial and administrative ability to maintain a nursing home in compliance with these regulations, including submission of an audited financial statement, whether or not the applicant ever operated a nursing home, related institution, or other health care facility.
10. Bill of sale documenting the date of the transaction.
11. 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.
12. 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 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).

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

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

- **License Approval - Non-expiring:**
  - o If the applicant meets all licensure requirements, a non-expiring license to operate a nursing home will be issued to the applicant.
- **License Approval with Conditions:** OHCQ may issue a license with conditions.
  - o Examples of conditions include requiring the applicant to use the services of a management firm, requiring a staffing pattern, or limiting admissions to the nursing home. The cover letter will fully explain the conditions.
- **License Denial:** If you are unable to comply with all of the licensure requirements, then your application will be denied.
  - o 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 10.07.02.04](#). 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.

### **Sale, Transfer Assignment, or Lease of a Nursing Home**

Per COMAR 10.07.02.04B(4), if the sale, transfer, assignment, or lease of a nursing home causes a change in the person or persons who control or operate the nursing home, the nursing home shall be considered a “new nursing home” and the licensee shall conform to all regulations applicable at the time of transfer of operations.

The transfer of any stock which results in a change of the person or persons who control the nursing home, or a 25 percent or greater change in any form of ownership interest, constitutes a sale.

### **Waiver of Provisions**

For purposes of Life Safety Code enforcement, the nursing home is considered to be an existing nursing home if it has been in continuous use as a nursing home. Waivers may be granted under [COMAR 10.07.02.03G](#).

If a nursing home experiences practical difficulties or unnecessary hardships in complying with the provisions of [COMAR 10.07.02](#), and can demonstrate that granting a waiver will not adversely affect the health and safety of its residents, the Secretary may waive any provision of this chapter. A waiver granted to a nursing home is effective for the period specified in the waiver. A waiver may be revoked at any time if a nursing home violates a condition of the waiver or if it appears to the Secretary that the health or safety of residents residing in the nursing home would be adversely affected by the continuation of the waiver.

### **Return of License to the Secretary of Health**

Per COMAR 10.07.02.04B(5), the license shall immediately become void and must be returned to the Secretary if the:

1. Nursing home is sold, leased, or discontinued;
2. Operation moved to a new location; or
3. License is revoked.

## **A. General Information**

Type of Application:  Change of Ownership

Legal Name of Business:

Doing Business As or Trade Name:

FEIN Number:

Street Address:

City, State, Zip Code:

County:

Business Phone:

After Hours Emergency Phone:
Fax Number:
Agency Email:
Agency Website:
Provide the name and contact information for the primary and secondary contacts for the purpose of this application.
In order to discuss this licensure application and the information contained within with any person or entity other than the applicant, OHCQ must obtain written consent from the applicant's designated primary or secondary contact.
Name of Primary Contact:
Title of Primary Contact:
Business Email of Primary Contact:
Business Phone of Primary Contact:
Alternate Phone of Primary Contact:
Name of Secondary Contact:
Title of Secondary Contact:
Business Email of Secondary Contact:
Business Phone of Secondary Contact:
Alternate Phone of Secondary Contact:
<b>B. Administrator</b>
Name of Administrator:
Maryland License Number:
Expiration Date:
Administrator's Business Email:
Administrator's Business Phone:
Administrator's Alternate Phone:
<b>C. Leasing Arrangement</b>
Skip this section if the entity does not operate the business under a lease.
What is the expiration date of the lease?
Name of Lease:
Street Address:
City, State, and Zip Code:
Name of Lessor:
Street Address:
City, State, and Zip Code:

<b>D. Services</b>
Total number of licensed beds requested:
Do you intend to continue operating an existing and approved respiratory care unit? Yes      No      If yes, submit documentation of all requirements under <a href="#">COMAR 10.07.02.23</a> and <a href="#">10.07.02.24</a> to OHCQ.
How many beds are in the unit?
Is the unit is being relocated within the building? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you intend to continue operating an existing and approved dementia care unit?      Yes      No If yes, submit documentation of all requirements under COMAR 10.07.02.23 and 10.07.02.25 to OHCQ.
How many beds are in the unit?
Is the unit being relocated within the building? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Room and Bed Breakdown</b>
<i>Example:</i>
<i>Floor: 2</i>
<i>Unit Name: 2 North</i>
<i>Room Type: Duplex</i>
<i>Bed Numbers: 201A, 201B, 203A, 203B, 205A, 205B, 207A, 207B, 209A, 209B, 211A, 211B</i>
<i>Total Beds: 12</i>
1. Floor:
1a. Unit Name:
1b. Room Type:
1c. Bed Numbers:
1d. Total Beds:
2. Floor:
2a. Unit Name:
2b. Room Type:
2c. Bed Numbers:
2d. Total Beds:
3. Floor:
3a. Unit Name:
3b. Room Type:
3c. Bed Numbers:
3d. Total Beds:
4. Floor:
4a. Unit Name:
4b. Room Type:
4c. Bed Numbers:
4d. Total Beds:
5. Floor:
5a. Unit Name:
5b. Room Type:
5c. Bed Numbers:

5d. Total Beds:
6. Floor:
6a. Unit Name:
6b. Room Type:
6c. Bed Numbers:
6d. Total Beds:
7. Floor:
7a. Unit Name:
7b. Room Type:
7c. Bed Numbers:
7d. Total Beds:
8. Floor:
8a. Unit Name:
8b. Room Type:
8c. Bed Numbers:
8d. Total Beds:
9. Floor:
9a. Unit Name:
9b. Room Type:
9c. Bed Numbers:
9d. Total Beds: .
10. Floor:
10a. Unit Name:
10b. Room Type:
10c. Bed Numbers:
10d. Total Beds:
11. Floor:
11a. Unit Name:
11b. Room Type:
11c. Bed Numbers:
11d. Total Beds:
12. Floor:
12a. Unit Name:
12b. Room Type:
12c. Bed Numbers:
12d. Total Beds:
13. Floor:
13a. Unit Name:
13b. Room Type:
13c. Bed Numbers:
13d. Total Beds:

## E. 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 administrative and procedural requirements contained in COMAR 10.07.02 (Regulations governing Comprehensive Care Facilities and Extended Care Facilities) in the areas of written administrative and resident care policies, by-laws and other organizational documentation, written agreements with outside resources/consultants, committee meetings, staff qualifications and written development program such as in-services, equipment maintenance and disaster preparedness have not been substantively altered, revised, or modified, since the previous survey, or if they have, I have notified the Office of Health Care Quality, in writing, before the effective date of the change.

I further certify that I will notify the Office of Health Care Quality if there are any future “substantive changes in facility management and operation, “ as defined in the instructions for completion of the Federal affidavit, that significantly affect policies and procedures and that notice will be given in writing before the effective date of the change.

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, including the administrative and procedural requirements in COMAR 10.07.02.

Whoever knowing and willfully makes or causes to be made a false statement or representation on this statement may be prosecuted under applicable State laws. In addition, knowing and willfully failing to fully and accurately disclose the information requested may result in denial of a request to become licensed or, where the entity is already licensed, a revocation of that license.

Applications on behalf of a legal entity shall be made by the senior officer or other senior official and a second official, if any.

Full Name of Applicant 1:

Title of Applicant 1:

Signature of Applicant 1:

Date of Applicant 1 Signature:

Full Name of Applicant 2:

Title of Applicant 2:

Signature of Applicant 2:

Date of Applicant 2 Signature: