Application Packet
For Acute General and Special Hospitals

The following licensure forms are to be completed and returned to the HMO and Hospital Quality Assurance Unit. Please note demographic information on the application will be used to update the CMS database. This information is used by "Hospital Compare" and the "Maryland Hospital Performance Guide." For information or questions call (410) 402-8016.

A. Hospital Application Forms

Please make sure the hospital's name, address, and telephone number are accurate and complete. For all Special Hospitals (chronic, rehabilitation, psychiatric, and pediatric,) include a room and bed breakdown. The Special Hospital categories are to be used only by hospitals with a "Special Hospital" license.

B. Facility Ownership
Attach a list of the hospital's Board of Directors.

C. Workers' Compensation Law Questionnaire

D. Certificate of Compliance, as applicable
There are specific conditions in which an employer is granted exemption from the Worker's Compensation Insurance. (See attached Form C-16R)

E. "The Joint Commission" Report
Include a copy of the hospital's initial "Survey Report" from The Joint Commission that is posted on the extranet. The "Evidence of Standards Compliance", the final report and the "Award Letter" should be forwarded to OHCQ once the hospital has received those reports at a later date.

F. For hospitals also licensed as "Special Hospital – Rehabilitation", include a copy of the most recent survey report from the Commission Accreditation of Rehabilitation Facilities (CARF).

HOSPITAL APPLICATION

APPLICANT INFORMATION

Name of Facility: _____
Address: _____
City_____ State_____ Zip_____
Telephone: _____FAX: _____
Administrator Name _____
Title_____
Administrator's e-mail _____

Please select one of the following:

□ Individual □ Partnership □ Corporation □ Association □ Government Unit

Application on behalf of a corporation, government unit or agency shall be made by two officers of the corporations, association or governmental unit or agency and names of their board members shall be submitted.

HOSPITAL TYPE
(Check all that apply)

□ **Acute General:** Number of beds determined annually per Health General §19-309.1

For Hospitals Licensed as Special Hospitals only:

□ Special-Psychiatric – Number of Beds: _____
□ Special Chronic Disease – Number of Beds: _____
□ Special – Pediatric – Number of Beds: _____
□ Special Rehabilitation – Number of Beds: _____
□ Communicable Disease – Number of Beds: _____

Have any owners, officers, director, agents, or managerial employees have been convicted of a criminal offense involving any of the programs under Title 18, 10, or 20 of the Social Security Act? □ Yes □ No

I/We certify that I am/We are 18 years of age or older and of reputable and responsible character do hereby apply for a license to maintain and operate _____ subject to the provisions of Health-General Article, Title 19, Subtitle 3, Annotated Code of Maryland, and to the regulations adopted thereunder by the Secretary of Health.

1. Signature of Applicant _____ Title_____

2. Signature of Applicant _____Title _____

SEND COMPLETED APPLICATION TO: Office of Health Care Quality
Bland Bryant Building, Spring Grove Center
55 Wade Avenue
Catonsville MD 21228

OWNERSHIP FORM

Legal Name of Licensee (Disclosing entity)
Name:_____ License Number:_____
Address:_____
City:_____ State:_____ Zip:_____

Trading Name of License:_____

Type of Business Organization of Disclosing Entity (check one)

☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Other (Specify)
Date of Charter_____ Date of Incorporation_____

Names (s), title(s) and address (es) of owners, partners, officer(s), director(s), stock holder(s), and percentage owned if 2% or more (attach additional information)

Name & Title	Address	% Owned
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have any owners, officers, directors, agents, or managerial employees been convicted of a criminal offense involving any of the programs under Title 18, 10, or 20 of the Social Security Act? ☐ Yes ☐ No

TYPE OF CONTROL

Voluntary Non-profit	Proprietary	Government
☐ Church	☐	☐ State ☐ County ☐ City
☐ Other (Specify)		

Leasing Arrangement

If a disclosing entity operates the business under a lease, the following section shall be completed:

Lessee Name (s) and Address (es)

_____
Lessor Name (s) and Address (es)

_____
Expiration Date of Lease_____

By signing this form, the signee indicates full understanding that a violation will constitute grounds for revoking the license to operate a hospital or related institution in the State of Maryland.

_____ _____
Signature of Authorized Person Title

WORKERS' COMPENSATION LAW QUESTIONNAIRE

Name of Facility

(Please type or print)

Address of Facility

(Please type or print)

Do you have Workers' Compensation Insurance for your employees?
(Check one) □ Yes □ No

If you have answered **Yes** above; please provide the following information:

Policy Number_____

Binder Number_____

Insurance Company_____

Effective Date_____

Expiration Date_____

If you have answered **NO**, please attach a copy of your Certificate of Compliance in accordance with State Workers' compensation Laws. (See attached form A52 and Instruction Sheet)

Please note:

Your License cannot be issued unless this form is completed, signed, dated and provided to this Administration along with your "Certificate of Compliance" if applicable.

_____ _____

Signature **Date**

DHMH 3334