



STATE OF MARYLAND

DHMH

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Maryland Department of Health and Mental Hygiene  
Office of Health Care Quality  
Bland Bryant Building • Spring Grove Center  
55 Wade Avenue • Catonsville, Maryland 21228

Renewal Application Packet  
For Acute General and Special Hospitals

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*The following licensure forms are to be completed and returned to the HMO and Hospital Quality Assurance Unit within two weeks of the receipt of the hospital's Letter of Accreditation from the Joint Commission on Accreditation for Healthcare Organizations (JCAHO). Please complete all sections and be sure to provide required signatures and notary on the appropriate forms. Include the license fee of \$300.00 for the three-year license period. For information or question call (410) 402-8016. Make checks or money orders payable to:*

**“Maryland Department of Health and Mental Hygiene”**

**A. Hospital Application Form –**

For all Special Hospitals such chronic, rehabilitation, psychiatric, and pediatric, include a room and bed breakdown.

**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 Workers' Compensation Insurance. See attached form C-16R)*

**E. JCAHO report**

Include a copy of the hospital's JCAHO “Survey Report”, the “Evidence of Standards Compliance” and the “Award Letter” from the recently conducted triennial JCAHO survey.

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

## HOSPITAL APPLICATION

<b>APPLICANT INFORMATION</b>				
Name of Facility _____		Telephone No. _____		
Location _____				
(Street)				
_____		_____	_____	
(City)	(County)	(Zip)		
<b>Individual</b>	<b>Partnership</b>	<b>Corporation</b>	<b>Association</b>	<b>Government Unit</b>
<b>Applications on behalf of a corporation, association, governmental 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.</b>				
Administrator : _____		Title : _____		

<b>HOSPITAL TYPE</b> (Check all that apply)	
<b>Acute General:</b> Number of beds determined annually per Health-General 19-309.1 _____	
<b>Special-Psychiatric</b> Number of Beds _____	<b>Special-Chronic Disease</b> Number of Beds _____
<b>Special -Pediatric</b> Number of Beds _____	<b>Special -Rehabilitation</b> Number of Beds _____
<b>Other</b> (specify) _____	Number of Beds _____

Application fee of \$300 is to be attached to the application (Fee is not refundable). Make check or money order payable to "Maryland State Department of Health and Mental Hygiene."

Have any owners, officers, directors, agents, or managerial employees been convicted of a criminal offense involving any of the programs under Title 18, 19, or 20 of the Social Security Act?

YES                      NO

I/We \_\_\_\_\_  
(please print)

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 a facility 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 and Mental Hygiene.

1. **Signature of Applicant** \_\_\_\_\_ **Title** \_\_\_\_\_

2. **Signature of Applicant** \_\_\_\_\_ **Title** \_\_\_\_\_

Sworn and subscribed to before me this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_ a Notary Public for the State of Maryland.

My Commission expires \_\_\_\_\_  
\_\_\_\_\_  
Notary Public

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

<b>FOR OFFICE USE ONLY</b>		
<b>Initial</b>	<b>Date:</b> _____	<b>Amt Pd:</b> _____
<b>Renewal</b>	<b>Ck#:</b> _____	<b>Coord Name:</b> _____
<b>Change of Ownership</b>	<b>Registration #:</b> _____	<b>License #:</b> _____

**OWNERSHIP FORM**

**Legal Name of Licensee (Disclosing entity)**

Name: \_\_\_\_\_ License #: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Trading Name of Licensee \_\_\_\_\_  
(Facility's name)

**Type of Business Organization of Disclosing Entity (Check One):**

Sole Proprietorship     Partnership     Corporation     Other (Specify)  
Date of Charter \_\_\_\_\_ Date of Incorporation \_\_\_\_\_

**Name(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, 19, or 20 of the Social Security Act?

YES             NO

**TYPE OF CONTROL**

**Voluntary Non-profit**

Church  
 Other (Specify)

**Proprietary**

**Government**

State             City  
 County

**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 long term care facility or related institution in the State of Maryland.**

\_\_\_\_\_  
Signature of Authorized Person

\_\_\_\_\_  
Title

**Sworn and subscribed to before me this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_, a notary public for the State of Maryland.**

My commission expires: \_\_\_\_\_ Notary Public: \_\_\_\_\_

## WORKERS' COMPENSATION LAW QUESTIONNAIRE

Name of Facility

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(Please type or print)

Address of Facility

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(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

## INSTRUCTION SHEET

Please **REVIEW INSTRUCTIONS BEFORE** Completing the Certificate of Compliance Application

The Workers' Compensation Commission will accept only the original application, (Do not fax, photocopy or electronically reproduce). Type or print **LEGIBLY** (or application may be returned without review). Complete application in its entirety.

Line #1 Name of Company (If the company does not have a name leave blank)

Line #2 Owner's Name (If corporation, list the name of a contact person)

Line #3 Complete Business Address (P. O. Box Not Acceptable)

Line #4 Complete Mailing Address

Line #5 Phone Number (Pager Number Not Acceptable)  
FEIN or Social Security Number required (If partnership, please initial & list the last four digits of SS# for each partner.)  
If using a FEIN #, SS #'s are not necessary.

Line Check appropriate box (see back of application). Additionally, where indicated, please complete and attach Exclusion Form C-16R.

Line #7 Sign and Date (If partnership, all partners must sign.)

**NOTE: Maryland Law § 9-201 requires an employer with one or more employees to carry workers' compensation insurance. Any employer with workers' compensation insurance is to submit proof (policy or binder number) of coverage to the Agency where they are applying for their license. DO NOT COMPLETE THE CERTIFICATE OF COMPLIANCE APPLICATION IF YOU HAVE INSURANCE COVERAGE. If you have any questions regarding the Certificate of Compliance, please call (410) 864-5297 or 1 (800) 492-0479 and ask to be transferred to extension 5297. If you do not follow the aforementioned instructions, it may cause a delay in the processing of your application. Thank you for your cooperation.**

# CERTIFICATE OF COMPLIANCE

Before a governmental unit may issue a license or permit to a business for the purpose of engaging in an activity in which the business might employ a covered employee, the business shall submit to the governmental unit:

- (1) a certificate of compliance with this title; or
- (2) the number of a workers' compensation insurance policy or binder.

If a business is not covered by a workers' compensation insurance policy, an application to secure a Certificate of Compliance shall be submitted to the Workers' Compensation Commission pursuant to Labor & Employment Article §9-105. The sole purpose of a Certificate of Compliance is to identify those businesses which are not required to carry workers' compensation insurance coverage and to enable that business to apply for and obtain a license or permit from a government agency that requires proof of workers' compensation insurance coverage. A Certificate of Compliance is not workers' compensation insurance and is not binding on the Workers' Compensation Commission under any circumstance.

**NOTE: Maryland Annotated Code LE §9-201 requires a business with one or more employees to carry workers' compensation insurance.**

**Eligibility:** A business may secure a Certificate of Compliance in the name of the business, only if:

- (a) the business is a sole proprietor with no employees;
- (b) the business is a partnership with no employees other than the individual partners;
- (c-f) the business is a Farm Corporation, a Maryland Close Corporation, a Professional Corporation or a Limited Liability Company with no employees other than corporate officers or limited liability company members who have elected, under §9-206, to be excluded from workers' compensation coverage;
- (g) the business is an employer of only "casual employees" as provided under LE §9-205 and defined in Maryland Law; or
- (h) the business is an owner operator of a Class F (Tractor) vehicle who meets the requirements of exclusion as defined under LE §9-218.

Mail Application to: The Workers' Compensation Commission  
Attention: Certificate of Compliance Officer  
10 East Baltimore Street • Baltimore, Maryland 21202-1641

**Facsimile Applications Will Not Be Accepted. Do not photocopy or electronically reproduce.**

Licensing Agency's  
Stamp

# APPLICATION FOR CERTIFICATE OF COMPLIANCE

(Please type or print legibly. Review instructions on reverse side prior to completing application)

1. \_\_\_\_\_  
Name of Business (If trading as self, leave blank)

2. \_\_\_\_\_  
Name of Owner(s) If a partnership, print each partner's name (attach separate sheet if necessary)

3. \_\_\_\_\_  
Business Address (P. O. Box Not Acceptable)      City      State      Zip Code

4. \_\_\_\_\_  
Mailing Address      City      State      Zip Code

5. (\_\_\_\_\_) \_\_\_\_\_  
Phone Number (Pager Number Not Acceptable)      FEIN or Social Security Number(s)

6. The above named business would qualify for a Certificate of Compliance for the following reason: (Check the appropriate box and do not modify or qualify the stated reasons in any way.)

- a.  Sole Proprietor: The business is a sole proprietorship with no employees.
- b.  Partnership: The business is a partnership with no employees other than the individual partners.
- c.  A Maryland Close Corporation (attach Exclusion Form C-16R): The business is a Maryland Close Corporation with no employees other than corporate officers.
- d.  Farm Corporation (attach Exclusion Form C-16R): The business is a farm corporation with no employees other than corporate officers.
- e.  Professional Corporation (attach Exclusion Form C-16R): The business is a professional corporation with no employees other than corporate officers.
- f.  Limited Liability (attach Exclusion Form C-16R): The business is a limited liability company with no employees other than limited liability company members.
- g.  Casual Employees: The business only employs casual workers as provided in LE §9-205 and defined under Maryland Laws.
- h.  Owner/Operator of Class F Vehicle: The business is that of an owner operator of a Class F (Tractor) vehicle and meets the requirements of exclusion as defined under LE §9-218.

**I AFFIRM UNDER THE PENALTIES OF PERJURY THAT THE FOREGOING INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE, INFORMATION AND BELIEF.**

7. \_\_\_\_\_  
Signature(s) If a partnership, all partners must sign      Date  
(Use separate sheet if necessary)

After careful review of this application and based solely on the information contained in or attached to this application, the application is  APPROVED  DISAPPROVED.

\_\_\_\_\_  
Authorized Signature      Date

**An applicant who receives notice of disapproval may: (1) reapply for a certificate of compliance or (2) appeal the rejection in accordance with §§ 10-222 and 10-223 of the State Government Article.**

**WORKERS' COMPENSATION COMMISSION**

10 East Baltimore Street  
Baltimore, Maryland 21202-1641  
TEL: (410) 864-5100 OR (1-800) 492-0479  
TTY USERS CALL VIA MARYLAND RELAY

Date Stamp - WCC Use Only

**EXCLUSION FORM**

Pursuant to the provisions of Labor & Employment Article § 9-206 of the Annotated Code of Maryland, officers or members of a Farm Corporation, Close Corporation, Professional Corporation, or Limited Liability Company are covered employees if the officer or member provides a service for monetary compensation. Such officers or members who satisfy the criteria of Labor & Employment Article § 9-206(b) may elect to become excluded from coverage by filing this Exclusion Form with the Commission.

To exercise this option, any officer or member from the aforementioned types of organizations wishing to be excluded must sign this document. **NOTE: By signing this Exclusion Form below, each officer or member affirms under the penalties of perjury that the information contained in this form is true and correct as to that officer or member, to the best of the officer's or member's knowledge, information, and belief.**

DATE: \_\_\_\_\_ DATE COMPANY NOTIFIED INSURANCE COMPANY: \_\_\_\_\_

NAME OF CORPORATION'S INSURANCE COMPANY: \_\_\_\_\_

NAME OF COMPANY: \_\_\_\_\_

TYPE OF COMPANY: (Circle One) Farm Corporation, Close Corporation, Professional Corporation, Limited Liability Company

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

Typewritten Name and Title of Officer or Member Electing Exclusion	% of Ownership	Personal Signature

**IMPORTANT:** Submit original form to the Workers' Compensation Commission, a copy to the insurer of the corporation, and keep a copy for your files.