



STATE OF MARYLAND

DHMH

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 COMPREHENSIVE CARE & EXTENDED CARE FACILITIES**

=====

The following licensure forms are to be completed and returned to the Long Term Care unit 90 days prior to license expiration. Please complete all sections and be sure to provide required signatures and notary on the appropriate forms. Include your licensure fee based on the LONG TERM CARE PROVIDER APPLICATION (golden rod). For information or questions call (410) 402-8201. Make check payable to:

Maryland Department of Health and Mental Hygiene

- A. Application for Licensure - (gold)
Room and Bed breakdown is required at the time of license renewal.**
- B. Principal Physician Agreement & Relief Physician Agreement (blue)**
- C. Director of Nursing Agreement (yellow)**
- D. Facility Ownership (green)**
- E. State Affidavit (pink)**
- F. Workers' Compensation Law Questionnaire (gray)**
- G. Certificate of Compliance, as applicable (white)**

(There are specific conditions in which an employer is granted an exemption from requiring Workers' Compensation Insurance. See attached form C-16R)

LONG TERM CARE PROVIDER APPLICATION (golden rod)

APPLICANT INFORMATION	E-mail _____	Fax _____
Name of Facility _____		Telephone No _____
Location _____		
(Street)		

(City)	(County)	(Zip)
<input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Association <input type="checkbox"/> Government Unit		
Applications on behalf of a corporation, association, 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.		
Administrator _____		Administrator License No: _____

LONG TERM CARE FACILITY TYPE	<input type="checkbox"/> Nursing Home Comprehensive Care Facility
Number of Beds _____	<input type="checkbox"/> Hospital Extended Care Facility
<input type="checkbox"/> Room & Bed breakdown attached	

The 2-year license fee of \$ _____ (see fee rates below) 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."

Fee: 1 – 50 beds, \$3,000., 51- 99 beds, \$5,000., 100+ beds, \$7,000. Transitional care unit, \$600.

Have any owners, officer, 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 there under 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 Hospital Center
55 Wade Avenue
Catonsville MD 21228

FOR OFFICE USE ONLY		
<input type="checkbox"/> Initial	Date: _____	Amt Pd: _____
<input type="checkbox"/> Renewal	Ck #: _____	Coord Name: _____
<input type="checkbox"/> Change of Ownership	Registration #: _____	License #: _____

LONG TERM CARE PROVIDER APPLICATION

PRINCIPAL PHYSICIAN AGREEMENT (blue)

Name of Facility: _____ License #: _____

NOTE: *The State Department of Health Regulations require that each Comprehensive Care Facility 10.07.02 arrange for a physician to serve as Principal Physician and a qualified relief to cover periods when his or her services are not available.*

As Principal Physician I agree to the following:

1. *I will determine that all residents admitted to the facility are admitted upon the recommendation of and remain under the care of a physician who can provide physician services to the patient as described in these regulations and in the facility's policies, and works with the facility to correct problems.*
2. *As necessary, I will advise the administration as the suitability of residents to be admitted or retained in the facility.*
3. *I will provide medical direction and coordination of the facility's medical care.*
4. *I will respond to emergency calls for physician services when the resident's attending physician is not available.*
5. *I will participate in the development of patient care policies, at least annually. I will participate in the review of policies to ascertain that the facility's operations are consistent with its written policies.*
6. *I will be responsible for the surveillance of employee's health program.*

Principal Physician (signature)

Date

Principal Physician Information (please type or print):

Name: _____
(first) (middle) (last)

Medical License Number: _____

Address: _____

City: _____ State: _____ Zip code: _____

Telephone Number(s): _____

LONG TERM CARE PROVIDER APPLICATION

RELIEF PHYSICIAN AGREEMENT (blue)

Name of Facility: _____ License #: _____

NOTE: *The State Department of Health Regulations require that each Comprehensive Care Facility 10.07.02 arrange for a physician to serve as Principal Physician and a qualified relief to cover periods when his or her services are not available.*

As Relief Physician I agree to the following:

1. *I will determine that all residents admitted to the facility are admitted upon the recommendation of and remain under the care of a physician who can provide physician services to the patient as described in these regulations and in the facility's policies, and works with the facility to correct problems.*
2. *As necessary, I will advise the administration as the suitability of residents to be admitted or retained in the facility.*
3. *I will provide medical direction and coordination of the facility's medical care.*
4. *I will respond to emergency calls for physician services when the resident's attending physician is not available.*
5. *I will participate in the development of patient care policies, at least annually. I will participate in the review of policies to ascertain that the facility's operations are consistent with its written policies.*
6. *I will be responsible for the surveillance of employee's health program.*

Relief Physician (signature)

Date

Relief Physician Information (please type or print):

Name: _____
(first) (middle) (last)

Medical License Number: _____

Address: _____

City: _____ State: _____ Zip code: _____

Telephone Number(s): _____

LONG TERM CARE PROVIDER APPLICATION

DIRECTOR OF NURSING AGREEMENT (Yellow)

Name of Facility: _____ **License #:** _____

This is to certify that I, _____ am a
Name

A **Registered Nurse**, registry number _____

A **Licensed Practical Nurse**, Board of Nursing registry number: _____

and employed as **Director of Nursing** for the above-name facility and carry the supervisory responsibilities of this position as described in State Regulations 10.07.02, para. .12.C & G.

My agreement with the **Administrator** requires that I be on duty _____ **days** per week and work a minimum of 40 hours per week.

Director of Nursing (signature)

Date

The above statement is correct and in accordance with the conditions under which is employed by this facility.

(Director of Nursing)

Facility Administrator (signature)

Date of Agreement

OWNERSHIP FORM (green)

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

County

City

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: _____

STATE AFFIDAVIT (pink)

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 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 inservices, equipment maintenance and disaster preparedness have not been substantively altered, revised, or modified, since the previous survey, or, if they have, that 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.

NAME OF FACILITY:

Signature of Authorized Official	Title	Date
----------------------------------	-------	------

WORKERS' COMPENSATION LAW QUESTIONNAIRE (grey)

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

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.