

Office of Health Care Quality

Spring Grove Center, Bland Bryant Building
55 Wade Avenue, Catonsville, Maryland 21228
(410) 402-8217 Toll-free: 1 (877) 402-8221 Fax: (410) 402-8212

Assisted Living Program (Please Check Type of Application)

Initial Application

Change of Ownership Application Effective Date: _____

Corporate Name of Assisted Living Home: _____
Street Address: _____ City _____ State _____ Zip _____
Trade Name of Assisted Living Home: _____
Street Address: _____ City/Co _____ State MD Zip _____
Program Phone: _____ Program Fax: _____
E-mail Address: _____ Website: _____
Name and Phone Number of Owner, Corporation, or Partnership: (This will be the entity to which the license is issued)

Does the Owner, Corporation, or Partnership operate and manage the assisted living program? Yes No
If no, identify the management structure and its relationship to the business owner.

How many residents do you currently serve? _____ Number of beds requested: _____
Level of care requested: (please check one) 1 2 3

Level 3 assisted living managers are required to have a 4-year college-level degree; 2 years experience in a health care related field and 1 year of experience as an assisted living program manager or alternate assisted living manager; or 2 years experience in a health care related field and successful completion of the 80-hour assisted living manager training program.

Name of Assisted Living **Manager**: _____
Phone Number: _____ Cellular Number: _____
Home Address (City, State & Zip Code): _____

Alternate managers are required to have 2 years of experience in a health-related field.

Name of Assisted Living **Alternate Manager**: _____
Phone Number: _____ Cellular Number: _____
Home Address (City, State & Zip Code): _____

Name of Assisted Living **Delegating Nurse**: _____
Phone Number: _____ Cellular Number: _____
Home Address (City, State & Zip Code): _____

(If the provider does not have a contract or has not yet employed a Delegating Nurse, the applicant shall notify this Office either by postal mail or e-mail before admitting any residents. If the Delegating Nurse contract is terminated, OHQC must be notified in a reasonable timeframe.)

Has the applicant, owner, or managerial employee ever had a license, permit, or certificate to provide care to third parties that has been denied, suspended, or revoked? Yes No
If yes, explain: _____

Does the owner, applicant, assisted living manager, alternate assisted living manager, other staff, or any household member have a criminal conviction or other criminal history? Yes No
If yes, explain: _____

Trade Name of Assisted Living Home: _____
 Street Address: _____ City: _____ State MD Zip _____

During the 2002 General Session, Senate Bill (SB) 746, entitled *Alzheimer's Special Care Unit or Program*, was enacted into law. Assisted Living Programs offering services to individuals with Alzheimer's or a related disorder may need to develop a program description as outlined in the law. The definition contained in SB 746 is shown below. If your answer to the question is "yes," please follow the instructions for submission of your program description.

Is your facility planning to operate, or currently operating, an "Alzheimer's Special Care Unit or Program"?
 Yes No

If yes, please submit to this office a description of your Alzheimer's Special Care Unit, including the following:

- ✓ A written description of the special care unit or program using a disclosure form that has been adopted by the Department of Health & Mental Hygiene;
- ✓ A statement of the philosophy or mission;
- ✓ Description of how services in the Special Care Unit differ from the rest of the program;
- ✓ Staff training and staff job titles;
- ✓ Admission procedures, including screening criteria;
- ✓ Assessment and service planning protocol;
- ✓ Staffing patterns;
- ✓ A description of the physical environment and any unique design features appropriate to support the functioning of cognitively impaired individuals;
- ✓ A description of activities, including frequency and type;
- ✓ Charges to residents for services provided by the Alzheimer's Special Care Unit or Program;
- ✓ Discharge procedures; and
- ✓ Any services, training, or other procedures that are over and above those that are provided in the existing assisted living program.

Two (2) Year Application Fee Required:

- \$200.00 for 1-3 beds
- \$300.00 for 4-15 beds
- \$300.00 plus \$16.00 per bed for 16+ beds

Maryland Department of Aging (MDOA) and local health departments may collect additional fees.

Based upon the option chosen, please enclose two separate NON-REFUNDABLE business checks or money orders (application fee and materials fee). Make checks payable to the "**DHMH**." **NO PERSONAL CHECKS.**

"I, _____, do solemnly declare and affirm under penalties of perjury that the contents of the foregoing application are true to the best of my knowledge, information, and belief. 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 Department of Health and Mental Hygiene."

Signature of Owner(s) required:

Name	Title	Date
Name	Title	Date

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(For office use only)

License#: _____ **Fee: \$** _____ **Check/MO#:** _____ **Check/MO Date:** _____

Listed Below Are the Requirements to Become an Assisted Living Program

DIRECTIONS: Please submit **ALL** applicable documentation listed below (pages 3 to 6) to start an Assisted Living Program. Only when your documentation has been received in its entirety and approved will a nurse surveyor contact you to set up a paper review of the information on pages 7 and 8 of this packet. A site inspection will follow. Please mail your documentation to:

Spring Grove Center
Office of Health Care Quality
Assisted Living Program
55 Wade Avenue, Bland Bryant Building
Catonsville, Maryland 21228
ATTN: Barbara McCartin

- **Assisted Living Application** – Please complete the entire application, including the ownership form. If your facility is a corporation, please submit a copy of your good standing letter from the State of Maryland, Assessments & Taxation office. **THE OFFICE OF HEALTH CARE QUALITY (OHCQ) STRONGLY RECOMMENDS THAT PROVIDERS HAVE INTERNET ACCESS.** Please include your e-mail address with the application.
- **Application Fee** – Please submit a two (2) year application fee of \$200.00 (1-3 beds); \$300.00 (4-15 beds); or \$300.00 plus \$16.00 per bed for each bed over 15 (16+ beds) and a materials fee of \$25.00 (for Regulation Book & Long Term Care Diet Manual). Submit two **separate** business checks or money orders. Make both checks payable to “DHMH.” If you have already purchased the Regulation Book and Diet Manual only submit the application fee.
Note – If a facility fails to comply with COMAR 10.07.14 regulations and requires the OHCQ to conduct more than one on-site pre-licensure visit, OHCQ may charge \$250.00 per additional on-site visit.
- **Program Directions** - Please send directions (you may use www.mapquest.com or a similar search engine) from 55 Wade Avenue, Catonsville, MD 21228, to your program’s address.
- **Workers’ Compensation Law Questionnaire** – If you have employees working in the program, please complete the questionnaire with insurance information. You may apply for workers’ compensation insurance through Workers’ Compensation Insurance (IWIF), 8722 Loch Raven Boulevard, Towson, MD 21286, (410) 494-0011 or toll-free at 1 (800) 264-4943. If you do not have insurance, check “no” on the questionnaire and complete an application for the Certificate of Compliance.
- **Certificate of Compliance** – Please complete the certificate of compliance application included in your assisted living information packet. Mail the application to The Workers’ Compensation Commission (WCC), ATTN: Certificate of Compliance Officer, 10 East Baltimore Street, Baltimore, MD 21202-1641. Once your application has been approved by WCC, they will mail your certificate to you. A copy of your certificate must be included with your documentation. A Certificate of Compliance is only needed if you are a Corporation/LLC with no employees. **(IF YOU ARE OPERATING YOUR FACILITY AS A SOLE PROPRIETORSHIP OR PARTNERSHIP, THE CERTIFICATE OF COMPLIANCE IS NOT NEEDED IF YOU DO NOT HAVE ANY EMPLOYEES.)**

- **Hand Drawn Sketch** – Please complete a hand drawn sketch of your physical site with measurements of all rooms on a letter size (8½” x 11”) sheet of paper. Use a separate sheet of paper for each level of the building. **(NOTE: Label each room on your sketch and indicate measurements.)**

- **Criminal Background Check or Criminal History Records Check** (COMAR 10.07.14.07A(5)(d), COMAR 10.07.14.15A(1)(f), COMAR 10.07.14.18D, and COMAR 10.07.14.19B(3)). Please complete the form entitled “Individuals Requiring Criminal Background Checks (IRCBC).” The owner, applicant, manager, alternate manager, household members, and any other staff must have a state criminal history record check done. Once you return the IRCBC form, this office will send everyone listed on the form a CJIS-011 application form. The form(s) should be forwarded to the Department of Public Safety and Correctional Services, Criminal Justice Information System (CJIS) Central Repository. For additional information, CJIS representatives can be contacted at (410) 764-4501 or 1 (888) 795-0011 to apply for a state criminal history records check.

- **Zoning Approval and/or Use & Occupancy Permit** – Please send a copy of your zoning approval and/or use & occupancy permit. If your county is not listed, you must apply for 6+ beds within your county’s zoning & permits office.

County Zoning and Permits Offices

- **Anne Arundel County (6+ beds)**, Anne Arundel County, Office of Planning & Zoning, 2664 Riva Road, Post Office Box 6675, Annapolis, Maryland 21401, (410) 222-7274
- **Baltimore City (4+ beds)**, Baltimore City at Department of Housing and Community Development, Construction and Buildings Inspection Division, 417 E. Fayette Street, Room 100, Baltimore, Maryland 21202, (410) 396-3470
- **Baltimore County (all beds)**, Baltimore County Department of Permits and Development Management, ATTN: Zoning Review Office, Development Processing County Office Building, 111 W. Chesapeake Avenue, Towson, Maryland 21204, (410) 887-3391
- **Carroll County (6+ beds)**, Carroll County Government, 225 N. Center Street, Westminster, Maryland 21157, (410) 386-2790
- **Cecil County (9+ beds)**, Cecil County Government, 129 E. Main Street, Elkton, Maryland 21921, (410) 996-5220
- **Charles County (6+ beds)**, Charles County Permits Administration, Post Office Box 2150, LaPlata, Maryland 20646, (301) 645-0692 or (301) 645-0600
- **Frederick County (all beds)**, Frederick County Department of Planning & Zoning, Winchester Hall, 12 E. Church Street, Frederick, Maryland 21701, (301) 694-1134
- **Harford County (3+ beds)**, Harford County Government, Department of Planning and Zoning, 220 S. Main Street, Bel Air, Maryland 21014, (410) 638-3000
- **Kent County (6+ beds)**, The County Commissioner of Kent County, Office of Housing & Community Development, Kent County Government Center, 400 High Street, Chestertown, Maryland 21620, (410) 778-7475

- **Montgomery County (9+ beds)**, Montgomery County Government, Department of Permitting Services, 255 Rockville Pike, 2nd Floor, Rockville, Maryland 20850, (240) 777-6300
- **Prince George's County (6+ beds)**, Prince George's County, Department of Environmental Resources, Permits and Review Division, 9400 Peppercorn Place, Largo, Maryland 20774, (301) 883-5900
- **St. Mary's County (6+ beds)**, St. Mary's County Government, 23150 Leonard Hall Drive, Leonardtown, Maryland 20650, (301) 475-4200

(If your jurisdiction is not listed, please call information or see your local yellow pages for your county's zoning information.)

- **Menus & Healthy Meal Availability** – Please submit one of the following options:
 - Proof of purchase of the Diet Manual **AND** a 4-week menu cycle for a regular diet
OR
 - A 4-week menu cycle for a regular diet with documentation by a licensed dietician or licensed nutritionist that the menus are nutritionally adequate.
- **Uniform Disclosure Statement** – Please complete the form and return with your application.
- **Food Service Permit** – Please send in a copy of your program's food service permit for **17+ bed** programs, except in Baltimore City.
- **Howard County Rental License** – For all Howard County program addresses, please send in a current copy of your Howard County Rental License. You may contact Howard County Inspections, Licenses & Permits, 3430 Court House Drive, Ellicott City, Maryland 21043-4395, (410) 313-3800. **(This includes the Fire Inspection Report and/or Zoning Permit.)**
- **Montgomery County License** – All Montgomery County group homes/assisted living facilities for three or more residents must have both a Montgomery County license and a State license to operate. For an application and additional information, contact Licensure and Regulatory Services at (240) 777-3986. In addition, all environmental and fire inspections are done through this office once an application is completed.
- **Verification of Building Ownership and/or Control** – Please submit a copy of verification showing the building is owned, leased, or otherwise under the control of the assisted living applicant.
- **Environmental Report** - Please send a copy of your county's environmental report.
 - **(4+ beds) Baltimore City** Health Department, Environmental Health Services, 210 Guilford Avenue, 2nd Floor, Baltimore, Maryland 21202, (410) 396-4544
 - **(1 to 3 beds) Baltimore County** Department of Health, Medical Environmental Health, 6401 York Road, Baltimore, Maryland 21212, (410) 887-6008
- **Fire Inspection Report** - Please send in a copy of your approved fire inspection report. All programs that are applying for 1 to 5 beds will have to be inspected by this office, **EXCEPT** Baltimore City and Baltimore, Montgomery, and Prince George's counties (unless otherwise stated by P.G. County). Please note the telephone numbers for the following jurisdictions:

County Fire Department Offices

This office can only accept reports from your county's fire department or the MD State Fire Marshal's Office. Fire inspections from independent contractors are NOT acceptable.

- **(6+ beds) - Anne Arundel County Fire Department, Fire Marshal Division, 2660 Riva Road, Suite 290, Annapolis, Maryland 21401, (410) 222-7884**
- **(All Beds) - Baltimore City Fire Department, 414 N. Calvert Street, Baltimore, Maryland 21202, (410) 396-5752**
- **(4+ beds) - Baltimore County Fire Prevention Bureau, (410) 887-4883**
- **(6+ beds) - Montgomery County Fire & Rescue Service, 255 Rockville Pike, Rockville, Maryland 20850, (240) 777-2457**
- **(All Beds) - Prince George's County Fire/EMS Department, Fire Prevention Office, Fire Services Building, 6820 Webster Street, Landover, Maryland 20784, (301) 583-1830**
- **(6+ beds) - Worcester County, Office of the Fire Marshal, Government Office Center, Snow Hill, Maryland 21863, (410) 632-5666**
- **(6+ beds) - MD State Fire Marshal's Office, 1201 Reisterstown Road, Pikesville, Maryland 21286, (410) 653-8980**

If your county is not listed above, please contact the Maryland State Fire Marshal's Office to arrange for a fire inspection.

PLEASE BRING THE FOLLOWING INFORMATION FOR YOUR SCHEDULED PAPER REVIEW WITH THE OHCQ NURSE SURVEYOR.

- **Verification of Age** – The applicant, corporate representative, assisted living manager, alternate manager, and any individual or corporate owner of 25 percent or more interest in the assisted living program must submit a copy of a driver’s license or identification card issued by the State of Maryland.
- **Verification of Education and/or Work Experience** – The assisted living manager of a **level 3** licensed program must provide written evidence of: a 4-year college-level degree; or 2 years (full-time) or 4 years (part-time) experience in a health care related field and 1 year of experience as an assisted living program manager or alternate assisted living manager; or 2 years experience in a health care related field and successful completion of the 80-hour assisted living manager training program. The alternate manager must provide written evidence of 2 years of experience in a health-related field.
- **Health Record** - The alternate manager must submit a doctor’s written statement that they are free from any impairment which would hinder the performance of assigned duties.
- **Communicable Disease Statement** - The assisted living manager and alternate manager must submit written evidence that they are free from communicable tuberculosis and immune to measles, mumps, rubella, and varicella. See COMAR 10.07.14.15A and 10.07.14.18D for more details.
- **Assisted Living Manager Training Requirements** – Please submit proof of the following trainings. See COMAR 10.07.14.15 and 10.07.14.19G.
 - Assisted Living Manager’s 80-Hour Training Course – Please see 10.07.14.16 for training requirements and/or exemptions
 - Health and psychosocial needs of the population being served
 - Resident assessment process
 - Use of service plans
 - Cuing, coaching, and monitoring residents who self-administer medications
 - Providing assistance with ambulation, personal hygiene, dressing, toileting, and feeding
 - Resident rights
 - Fire and life safety
 - Infection control (including standard precautions)
 - Emergency disaster plans
 - Basic food safety
 - Basic first aid
 - Basic CPR (cardiopulmonary resuscitation)
 - Dementia/Alzheimer’s training

- **Alternate Manager Training Requirements** – Please submit proof of the following trainings. See COMAR 10.07.14.18D and 10.07.14.19G.
 - Fire and life safety (including the use of fire extinguishers)
 - Infection control (including standard precautions, contact precautions, and hand hygiene)
 - Basic food safety
 - Emergency disaster plans
 - Basic first aid
 - Health and psychosocial needs of the population being served
 - Resident assessment process
 - Use of service plans
 - Resident rights
 - Dementia/Alzheimer’s training

- **Policies and Procedures** – Please submit a copy of your program’s policies and procedures to be implemented in accordance with the following COMAR regulations:
 - COMAR 10.07.14.24D(7)(a) - Bed and Room Assignment Policy
 - COMAR 10.07.14.24D(7)(b) – Change in Resident’s Accommodation Procedure
 - COMAR 10.07.14.24D(7)(c) – Transferring of Resident to Another Facility Procedure
 - COMAR 10.07.14.24D(8)(c) – Resident Discharge Procedure
 - COMAR 10.07.14.24D(8)(d) – Resident’s Request to Terminate an Agreement Procedure
 - COMAR 10.07.14.27C – Policies and procedures to ensure all pertinent information relating to a resident’s condition/preferences is documented in the record and communicated to the appropriate persons
 - COMAR 10.07.14.24D(6) & .35A(18) – Complaint and Grievance Procedure
 - COMAR 10.07.14.36A – Policy and procedures prohibiting abuse, neglect, and exploitation of residents
 - COMAR 10.07.14.46C – Emergency and Disaster Plan Procedure
 - COMAR 10.07.14.47A,B(1)-(3) – Smoking Policy
(See attached helpful hints to assist you in developing your policies & procedures.)

- **Resident Agreement** (COMAR 10.07.14.24 & .25) – Please submit a typed copy of your program’s resident agreement (see sample in information packet).

- **Financial Disclosure** – Please submit a business plan and 1-year operating budget which demonstrates financial or administrative ability to operate an assisted living program.

- **Quality Assurance** – The assisted living program shall develop and implement a quality assurance plan.

Applicant/License Provider Name:

Business Address:

Important Factors in Becoming an Assisted Living Provider

I understand that:

- I may not operate an assisted living program in the State of Maryland without obtaining a license from the Secretary and complying with the requirements of COMAR 10.07.14 (Assisted Living Programs).
- If I provide housing under a landlord-tenant arrangement, this does not, in and of itself, exclude me from the licensure requirements of COMAR 10.07.14.
- I must maintain separate licenses for separate assisted living programs on the same or separate premises, even though the programs are operated by the same person.
- I may not provide services beyond the licensed specified number of beds and specified level of care.
- I shall conspicuously post my license at the facility.
- If I fail to comply with COMAR 10.07.14 and any other applicable State and local laws and regulations, I understand that this is grounds for sanctions, as specified in Regulations.56--.64 of COMAR 10.07.14.
- I may not use the words “hospital”, “sanitarium”, “nursing”, “convalescent”, “rehabilitative”, “sub-acute” or “hospice” in the title or advertising of my assisted living program.
- I may not advertise, represent, or imply to the public that my assisted living program is authorized to provide a service that the program is not licensed, certified, or otherwise authorized to provide by the Office of Health Care Quality.
- I may not provide day, partial, or hourly adult day care services without appropriate adult medical day care licensure. However, if an individual has applied for admission or has been admitted to the assisted living program they may, for a reasonable period of time not to exceed 30 days, transition to the program in increments of partial days before becoming a resident. All assisted living regulations (COMAR 10.07.14) apply to services and care provided during this transition period.
- If I falsify or alter an assisted living license, I shall be subject to referral for criminal prosecution and imposition of civil fines.
- The application license fee is nonrefundable.
- The owner, manager, alternate manager, or board member of an assisted living program that has had its license suspended or revoked by the Office of Health Care Quality may not own, operate, lease, or manage another assisted living program for 10 years without good cause shown. After 10 years, the applicant shall submit evidence to the Office of Health Care Quality that the applicant is capable of owning, managing, or operating an assisted living program.
- If an owner, manager, or alternate manager of an assisted living program operates, leases, or manages an assisted living facility and the facility has had sanctions imposed or deficiencies cited within the last two (2) years and has not corrected the deficiencies which present a risk to the health or safety of residents for a currently licensed assisted living facility, that owner, manager, or alternate manager may not apply to open an additional assisted living facility until those deficiencies have been corrected as approved by the Office of Health Care Quality.

Applicant/License Provider Name:

Business Address:

Important Factors in Becoming an Assisted Living Provider

I understand that:

- During the license period, a licensee may not increase capacity, change its name, or change the name under which the program is doing business, without the Office of Health Care Quality’s approval. When there is a change of program ownership or a change of location, the licensee shall submit a new application and written request for a new license and an application fee, as established in Regulation 10.07.14.07A(3).
- A licensee shall forward to the Office of Health Care Quality a copy of any report or citation of a violation of any applicable building codes, sanitary codes, fire safety codes, or other regulations affecting the health, safety, or welfare of residents within 7 days of receipt of the report or citation.
- When an assisted living program changes the services reported on its Uniform Disclosure Statement filed with the Office of Health care Quality under Regulation 10.07.14.07A(2)(b), the program shall file an amended Uniform Disclosure Statement with the Office within 30 days of the change in services.
- An assisted living program shall provide awake overnight staff when a resident’s assessment using the Resident Assessment Tool, as provided in Regulation .21A or .26B, indicates that awake overnight staff is required according to instructions on that tool. If a physician or assessing nurse, in the physician’s or nurse’s clinical judgment, does not believe that a resident requires awake overnight staff, the physician or assessing nurse shall document the reasons in the area provided in the Resident Assessment Tool. The licensee shall retain this documentation in the resident’s record.

I, _____, hereby certify that I have read the information contained in this document and understand that while licensed as an assisted living provider, I shall ensure compliance with these statements and applicable assisted living COMAR regulations. I understand and agree that the omission, misrepresentation, or concealment of any significant fact in any statement made in this application or any material associated with the application for licensure, may be considered sufficient reason for the denial of my application, or revocation or suspension of my license.

Signature of Applicant(s):

Name Title Date

Name Title Date

Ownership Form

The completion of this form is necessary for initial licensure and license renewal. Please attach the completed form to your license application. All spaces in this form must be completed. If a particular section does not apply, insert the phrase "Not Applicable" or "N/A."

Legal Name of Licensee _____

Trade Name of Licensee _____

Type of Business Organization of Disclosing Entity (check one):

SOLE PROPRIETORSHIP
 Name of Owner _____
 Address of Owner _____

PARTNERSHIP
 Name _____
 Address _____

Partner Information and Percentage Owned if 25% or More

Name	Title	E-mail Address	Telephone #	Address	% Owned

CORPORATION
 Name of Corporation _____
 Address of Corporation _____

Corporation President Name, Address, and Phone Number: _____

**Please Note: You must submit a copy of your good standing verification from the State of Maryland Assessments & Taxation office.

Officer, Director, Stockholder Information and Percentage Owned if 25% or More

Name	Title	E-mail Address	Telephone #	Address	% Owned

Date of Charter _____ Date of Incorporation _____ FEIN # _____

OTHER (specify)
 Should aforementioned corporation or partnership be wholly or partly owned by another organization, the following shall be completed with respect to the organization owning all or part of the disclosing entity. List percentage owned if 25% or more.
 Name _____
 Address _____

Name	Title	E-mail Address	Telephone #	Address	% Owned

Ownership Form

Type of Control (check one)

Voluntary Non-Profit

- Church
- Other (specify) _____

Proprietary

Government

- State
- County
- City
- City/County

Leasing Arrangement

If the disclosing entity operates the business under a lease, the following section shall be completed and a copy of the lease attached.

Lessee Name(s) & Address(es)
(also known as – Tenant)

Lessor Name(s) & Address(es)
(also known as – Landlord)

Expiration Date of Lease _____

“I, _____, do solemnly declare and affirm under penalties of perjury that the contents of the foregoing application are true to the best of my knowledge, information, and belief. 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 Department of Health and Mental Hygiene.”

(Please note that if the Assisted Living Program is going to be in more than one applicant’s name, each applicant’s signature is required on this form.)

Signature of Applicant(s):

Name Title Date

Name Title Date

Name Title Date

Name Title Date