

ADULT MEDICAL DAY CARE (AMDC) APPLICATION FOR LICENSURE

1. GENERAL INFORMATION

CHECK TYPE OF APPLICATION

<input type="checkbox"/> INITIAL	<input type="checkbox"/> CHANGE OF OWNERSHIP	<input type="checkbox"/> NAME CHANGE
<input type="checkbox"/> RENEWAL	<input type="checkbox"/> CHANGE OF LOCATION	<input type="checkbox"/> CHANGE IN CAPACITY

LEGAL AGENCY NAME	TRADING NAME (DBA)
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E-MAIL ADDRESS	PHONE NUMBER	FAX NUMBER
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BUSINESS ADDRESS (physical location)	MAILING ADDRESS (if different)
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NUMBER, STREET	NUMBER, STREET
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CITY	STATE	ZIP	CITY	STATE	ZIP
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COUNTY	LICENSE NUMBER (if applicable)
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NAME OF DIRECTOR (Last, First, Middle Initial)	PHONE NUMBER	CELL NUMBER
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REGISTERED NURSE ASSUMING OVERSIGHT RESPONSIBILITIES:		
NAME	LICENSE NUMBER	LICENSE EXPIRATION DATE

BUSINESS HOURS (in HH:MM format)							
	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
FROM:							
TO:							

HOURS THAT STAFF ARE PRESENT (in HH:MM format)							
	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
FROM:							
TO:							

NUMBER OF PARTICIPANTS	AMDC IS:
	<input type="checkbox"/> Attached to a nursing home <input type="checkbox"/> A freestanding building

INDICATE ALL HEALTH CARE SERVICES PROVIDED BY THE CENTER:

SERVICES	SERVICE PROVIDED		
	BY STAFF	THROUGH CONTRACT	BY STAFF & THROUGH CONTRACT
PHYSICAL THERAPY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OCCUPATIONAL THERAPY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SPEECH PATHOLOGY	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SOCIAL SERVICES AND COUNSELING	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PHYSICIAN SERVICES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LIST OTHER SERVICES:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. FEES

To determine the amount of the **non-refundable** license fee and accepted methods of payment, refer to the instruction guide.

FEE ATTACHED? Yes

3. OWNERSHIP (Type of business organization of disclosing entity)

SOLE PROPRIETORSHIP PARTNERSHIP CORPORATION
 ASSOCIATION GOVERNMENT UNIT MERGER LLP LLC

NAME _____ ADDRESS _____

IF PARTNERSHIP OR CORPORATION,
PARTNER, OFFICER, DIRECTOR, OR STOCKHOLDER INFORMATION AND PERCENTAGE OWNED IF 25% OR MORE

NAME AND TITLE	E-MAIL	PHONE NUMBER	ADDRESS	% OWNED

IF CORPORATION:
DATE OF CHARTER _____ DATE OF INCORPORATION _____ FEIN NUMBER _____

NAME OF PRESIDENT _____ PHONE NUMBER _____ CELL NUMBER _____
ADDRESS (number, street) _____ CITY _____ STATE _____ ZIP _____

4. WORKERS' COMPENSATION

Do you have any employees? Yes No

If you answered YES, provide your workers' compensation insurance information:

POLICY NUMBER _____ BINDER NUMBER _____
INSURANCE COMPANY _____ EFFECTIVE DATE _____ EXPIRATION DATE _____

If you answered NO, additional documentation from the Workers' Compensation Commission must accompany this application (refer to the instruction guide for details).

5. AFFIDAVIT

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 DHMH. In addition, knowingly and willfully failing to fully and accurately disclose the requested information 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 this agency is in compliance with the provisions of Health-General Article, Title 19, Subtitle 3, Annotated Code of Maryland and the administrative and procedural requirements pertaining to the Adult Medical Day Care Code of Maryland Regulations (COMAR 10.12.04).

I further certify that I will notify the OHCO if there are any future substantive changes in agency and operation, and that written notice will be given before the effective date of the change.

I hereby swear and affirm that I am over the age of 18 and I am otherwise competent to sign this Affidavit.

If the program is going to be in more than one applicant's name, each applicant's signature is required.

SIGNATURE OF APPLICANT _____	TITLE _____	DATE _____
SIGNATURE OF APPLICANT _____	TITLE _____	DATE _____

FOR OFFICE USE ONLY

DATE	AMOUNT PAID	CHECK #
COORDINATOR NAME	REGISTRATION #	LICENSE #