



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

RE: Application for Renewal  
Of Residential Service Agency Licensure

Enclosed is an application for renewal of your Residential Service Agency (RSA) license. Please submit your renewal application and licensure fee 30 days before your expiration date. If your license is not renewed before the expiration date, OHCQ will consider your agency terminated and Medicaid will be notified.

In accordance with the Code of Maryland Regulations 10.07.05, the following must be received by our office before a license can be issued:

1. The completed application, including the state affidavit.
2. A check or money order for \$500.00 (non-refundable) made payable to the Department of Health and Mental Hygiene.
3. A list of licensed and non-licensed personnel. **Note: Certification is required for aides; be sure to include licensure verification for all licensed employees.** Identify the position held by non-licensed personnel.
4. Identify lead licensed personnel.
5. A list of all Medicaid programs that your company has contracts with.
6. **Any changes in your policies and procedures since last licensure cycle.**
7. Completion of the **Residential Service Agency (RSA) Annual Data Collection Survey.**

**Please complete the entire application. Incomplete applications will be returned.**

Return the above information to:

Office of Health Care Quality  
Spring Grove Center  
Bland Bryant Building  
55 Wade Avenue  
Baltimore, Maryland 21228  
Attn: Elaine Horsey

**Page Two**

If you do not intend to renew your license, you must return your operating license to this office.

Please be advised that an unannounced on-site inspection of your facility may be performed to determine compliance with the RSA requirements. If you are operating as an unlicensed RSA program, you are in jeopardy of termination of your Medicaid provider number and reimbursement.

If you would like to have a copy of the above referenced regulations, send a separate check or money order for \$5.00 payable to the Department of Health and Mental Hygiene to Theresa Mullins, and request RSA Regulation COMAR 10.07.05 or log on to [www.dsd.state.md.us](http://www.dsd.state.md.us).

If you have questions regarding this notice, please contact Elaine Horsey at our Office at (410) 402-8267.

Sincerely,

Barbara Fagan  
Program Manager  
Ambulatory Care Programs  
Office of Health Care Quality

BF/edh

Enclosure: Residential Service Agency Renewal Application

cc: Nancy Cutair  
Division Chief  
Division of Nursing Services

**OFFICE OF HEALTH CARE QUALITY  
Residential Service Agency Licensure Application**

**Under the provisions of Code of Maryland Regulations (COMAR) 10.07.05, application is hereby made to operate a Residential Service agency in the State of Maryland.**

**Please indicate if license is: New \_\_\_\_\_ Renewal \_\_\_\_\_ (License No.) R\_\_\_\_\_**

**Official name of agency \_\_\_\_\_**

**Trading Name (dba) \_\_\_\_\_**

**Agency Address \_\_\_\_\_**

**Mailing Address \_\_\_\_\_  
(If different from above)**

**City \_\_\_\_\_ State/Zip \_\_\_\_\_ County \_\_\_\_\_**

**Business Phone No \_\_\_\_\_ Fax \_\_\_\_\_**

**Name of Administrator \_\_\_\_\_**

**A non-refundable application fee of five hundred dollars (\$500.00) is to be attached to the application. Make checks or money orders payable to the Maryland Department of Health and Mental Hygiene.**

**Page Two**

Home Care Services to be provided:

**CHECK ONE SERVICE GROUP ONLY!** (More than one service group checked will make application invalid.)

**Service Group One**

\_\_\_\_\_ Skilled Nursing Only

**OR**

\_\_\_\_\_ Skilled Nursing and one of the following:

(Select One)

\_\_\_\_\_ Aides

\_\_\_\_\_ OT

\_\_\_\_\_ PT

\_\_\_\_\_ Speech Therapy

\_\_\_\_\_ Medical Social Services

\_\_\_\_\_ Infusion Therapy

\_\_\_\_\_ Durable Medical Equipment

**Service Group Two**

\_\_\_\_\_ Infusion Therapy Only

**Service Group Three**

\_\_\_\_\_ Respiratory Therapy Only

**Service Group Four**

\_\_\_\_\_ Durable Medical Equipment Only

**Service Group Five**

\_\_\_\_\_ Durable Medical Equipment w/Oxygen

Category: For Profit ( ) Non Profit ( )

**Type of Ownership:**

**Individual/Sole Proprietorship**

Name of Owner \_\_\_\_\_

Address of Owner \_\_\_\_\_

**Partnership**

**Corporation**

If the applicant is a corporation, or partnership, list each officer or director, and the names of individuals holding 2% or more ownership. (Attach list if necessary)

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

**Page Three**

“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 shall 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.”

\_\_\_\_\_  
Print Name of Authorized Person

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

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

**By signing this form, the signee indicates full understanding that a violation will constitute grounds for revoking the license to operate a residential service agency in the State of Maryland.**

## **STATE AFFIDAVIT**

**Whoever knowingly and willfully makes or causes to be made a false statement or representation of this statement may be prosecuted under applicable State Laws. In addition, knowingly 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 this agency is in compliance with the administrative and procedural requirements pertaining to COMAR 10.07.05, Regulations governing RSA Agencies, in the areas of written administrative patient care policies and other organizational documentation.**

**I further certify that I will notify the Office of Health Care Quality if there are any future substantive changes in agency and operation that significantly affect policies and procedure that notice will be given, in writing, before the effective date of the change.**

**I hereby swear and affirm that I am over the age of 21, I am otherwise competent to sign this Affidavit, and that these statements are true and based upon my personal knowledge.**

**NAME OF AGENCY:** \_\_\_\_\_

\_\_\_\_\_  
**SIGNATURE OF AUTHORIZED OFFICIAL**

\_\_\_\_\_  
**TITLE**

\_\_\_\_\_  
**DATE**

## Residential Service Agency (RSA) Annual Data Collection Survey

1. **Current Residential Service Agency (RSA) License No.** \_\_\_\_\_  
**Licensed Name** \_\_\_\_\_  
**Street:** \_\_\_\_\_  
**City/State:** \_\_\_\_\_  
**Zip Code:** \_\_\_\_\_ **Area Code/Telephone:** \_\_\_\_\_  
**E-mail Address:** \_\_\_\_\_

**Contact Person:** \_\_\_\_\_ **Title:** \_\_\_\_\_  
**Person Completing Survey:** \_\_\_\_\_  
**Date Survey Completed:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

(Attach addresses and phone numbers of all Branch locations)

2. **The requested information reported in this survey is for the past 12-month period.**

**Beginning Date:**    \_\_\_ \_\_\_    \_\_\_ \_\_\_    \_\_\_ \_\_\_  
Month        Day        Year

**Ending Date:**     \_\_\_ \_\_\_    \_\_\_ \_\_\_    \_\_\_ \_\_\_  
Month        Day        Year

**Note:** If you are not reporting data for a complete 12-month period, select the appropriate response:

Newly established RSA   \_\_\_    RSA Closed   \_\_\_    Change in Ownership   \_\_\_  
**Other:** \_\_\_\_\_

3. **Which of the following services were consistently provided to clients by your RSA staff during this 12-month period? Please check appropriate boxes.**

Services Provided	Yes	No
Skilled Nursing		
Personal Care Services		
Physical Therapy		
Speech Therapy		
Occupational Therapy		
Homemaker/Chore		
Transportation		
Durable Medical Equipment		
Laboratory		
Infusion Company		
Medical Social work		
Ventilator Services		
Dietary and Nutritional Consultation		
Oxygen Therapy or other Medical Gas		

<b>Other (specify):</b>		
<b>Other:</b>		
<b>Other:</b>		

4. Report the Number of Full Time and Part Time employees for Administrative/ Support staff, Direct Care Personnel, Drivers, Maintenance Techs, and Supervisor Personnel during this 12-month period. Include independent contractors under agreement with your agency.

Type of Worker	Full Time Employees	Part Time Employees
Administrative Personnel		
Registered Nurses (RNs)		
Licensed Practical Nurses (LPNs)		
Certified Nurse Aides (CNAs)		
Geriatric Nurse Aides (GNA)		
Medication Technician		
Physical Therapists		
Occupational Therapists		
Speech Therapists		
Respiratory Therapists		
Home Health Aides		
Medical Social Workers		
Homemakers		
Companion		
Driver		
Maintenance Technician		
Other:		
<b>TOTAL</b>		

5. Report the Total Number of Admissions in the 12 month period (For DME Providers: Total Number of New Clients requiring home delivery of equipment):  
 Skilled Care \_\_\_\_\_ Unskilled Care \_\_\_\_\_ DME \_\_\_\_\_
6. Report the Total Number of Discharges in the 12 month period (For DME Providers: Total Number of Clients who terminated the need for home delivery of equipment):  
 Skilled Care \_\_\_\_\_ Unskilled Care \_\_\_\_\_ DME \_\_\_\_\_
7. List the agency's current census: \_\_\_\_\_
8. Report the Number of Skilled and Unskilled Care Clients Served During This Annual Reporting Period.
- A.) Number of Skilled Care Clients: \_\_\_\_\_  
 (Skilled care patients require care from a Registered Nurse or Licensed Practical Nurse)
- B.) Number of Unskilled Care Clients: \_\_\_\_\_ DME Clients \_\_\_\_\_  
 (Unskilled care patients require an assessment from a Registered Nurse, and care from a CNA)



**10. Are you licensed or provide care in any other State or in the District? \_\_\_\_\_**  
**If yes, please list (attach additional pages if needed):**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**11. A.) Report the Number of Clients Served by Payer Source**

<b>Payer Source</b>	<b>Number of RSA Clients</b>
<b>*Medicaid (Traditional)</b>	
<b>*Medicaid HealthChoice</b>	
<b>*Other Government</b>	
<b>Private Insurers</b>	
<b>HMO/Managed Care</b>	
<b>Self Pay</b>	
<b>*Other State Program, Please specify:</b>	
<b>Other, Please specify:</b>	
<b>Unknown</b>	
<b>TOTAL Clients =</b>	

**\*If RSA clients are from a State Program (Medicaid, Department of Aging, Department of Human Resource, etc.), report the specific Maryland State Program and appropriate contact person with phone number, below:**

**B. ) Report the Specific Maryland State Program with Contact Information**  
**(for additional programs, attach separate sheet)**

<b>Specific Maryland State Program</b>	<b>Name of Contact Person</b>	<b>Phone Number/E-mail</b>

**12. If Your RSA is a Durable Medical Equipment (DME) Provider,**  
**list the type of equipment provided**

<b>Type of Durable Medical Equipment</b>