Maryland Department of Health
Office of Health Care Quality
Application for Nursing Referral Service Agency License

Instructions

Applying for a License

Prior to operating a nursing referral service agency in Maryland, the agency must first obtain a nursing referral service agency license from the Office of Health Care Quality (OHCQ). COMAR 10.07.07.03. To apply for a license, complete this application. The application must be typed. Handwritten applications will be returned to the applicant. Submit the completed application and the required attachments through the "Submit a License Application" link on the OHCQ website. There is no fee to apply for a license.

Required Attachments:

1. Policies and procedures as required in COMAR 10.07.07.04.
2. Letter of Good Standing: The applicant must obtain an official letter of good standing from the Maryland Department of Assessment and Taxation (DAT), Business Express.
    a. To register a business in Maryland, use the following link: https://egov.maryland.gov/businessexpress
    b. When the business is currently active with Maryland DAT, conduct a search for the name of the business, click on the business name, and then click on "Order Documents" in the lower right-hand corner of the page.
3. Workers' Compensation: Attach a copy of the declaration page from your Workers' Compensation coverage. Those who need to acquire a Certificate of Compliance from Maryland Workers Compensation Commission can make the request to obtain the document by visiting the website: https://comphub.wcc.state.md.us/Web/Public/CertificateOfCompliance
    a. Corporations and limited liability companies who are not required to carry Workers' Compensation insurance coverage must submit a Certificate of Compliance.
    b. Sole proprietorships and partnerships that do not have any employees and who are not required to have Workers' Compensation insurance coverage must submit a Letter of Exemption.
    c. For more information, visit the Maryland Workers' Compensation Commission website, call 410-864-5293, or email wccinsur@wcc.state.md.us.

Change of Ownership

A licensee may not, under any circumstances, transfer or reassign its nursing referral service agency license to another person. COMAR 10.07.07.06. If the ownership is changing, the new owner must submit an initial license application and receive a new license prior to operating the agency.

If the agency ceases to operate for any reason, the license is void and the licensee shall immediately return the license to OHCQ. COMAR 10.07.07.06.

Determination of the Request for a License

Once your license application is complete, OHCQ will make one of the following determinations regarding your application:

- **License Approval**: After OHCQ determines that the applicant is in compliance with all licensure requirements, a license is issued to the applicant.
- **License Denial**: If you are unable to comply with all of the licensure requirements, then your application will be denied. If the application is denied, the applicant will receive a detailed letter explaining the reason for the denial and your appeal rights.
- **License Application Administratively Closed**: An application is not complete until the Department has received all the required application materials. OHCQ will hold an application for 180 days from the date of initial receipt, after which the application will be deemed inactive and administratively closed. An applicant whose application is administratively closed may reapply by submitting a new application.

Withdrawal of Application: An applicant may withdraw their license application at any time by notifying OHCQ in writing. An applicant may reapply by submitting a new application.

A. General Information

Type of Application: ☐ Initial ☐ Change of Ownership
Legal Name of Business:
Doing Business As or Trade Name:
FEIN Number:
Street Address:
City, State, Zip Code:
County:
Primary Business Phone:
After Hours Emergency Phone Number:
Fax Number:
Business Email:
Business Website:
Name of Director of Nursing:
Title of Director of Nursing:
Business Email of Director of Nursing:
Business Phone of Director of Nursing:
Name of Primary Contact:
Title of Primary Contact:
Business Email of Primary Contact:
Business Phone of Primary Contact:

B. Description of Services
What type of services will the applicant provide?
C. Ownership: Complete the section that is applicable
Sole Proprietorship - Skip this section if applicant is not a sole proprietorship
Name of Sole Proprietor:
Title:
Street Address:
City, State, and Zip Code:
Business Email:
Business Phone:
Business Fax:
Limited Liability Company (LLC) - Skip this section if applicant is not an LLC
Non-Maryland LLC: If this is an LLC formed in a State or territory outside of Maryland (including in Washington DC, Puerto Rico, Guam, and the U.S. Virgin Islands), or in another country, state where the LLC was formed.
Name of Limited Liability Company:
Street Address of Principal Office:
City, State and Zip Code:
Business Email of Principal Office:
Business Phone:
Business Fax:
Name of Resident Agent:
Street Address:
City, State, and Zip Code:
Business Email:
Business Phone:
Business Fax:
Enter the full name, street address, city, state, zip code, and business phone number for each member.
Full Name of Member 1:
Street Address for Member 1:

Phone Number for Member 1:
Full Name of Member 2:
Street Address of Member 2:
Phone Number of Member 2:
Full Name of Member 3:
Street Address of Member 3:
Phone Number of Member 3:
Full Name of Member 4:
Street Address of Member 4:
Phone Number of Member 4:
Full Name of Member 5:
Street Address of Member 5:
Phone Number of Member 5:
Partnership - Skip this section if applicant is not a partnership
Type of Partnership: ☐ Limited ☐ General
Name of Partnership:
Street Address of Principal Office:
City, State, and Zip Code:
Business Email of Principal Office:
Business Phone:
Business Fax:
Name of Resident Agent:
Street Address:
City, State, and Zip Code:
Business Email:
Business Phone:
Business Fax:
Enter the full name, street address, city, state, zip code, and business phone number for each partner..
Full Name of Partner 1:
Street Address for Partner 1:
Phone Number for Partner 1:
Full Name of Partner 2:
Street Address for Partner 2:
Phone Number for Partner 2:
Full Name of Partner 3:
Street Address for Partner 3:
Phone Number for Partner 3:
Full Name of Partner 4:

Street Address for Partner 4:
Phone Number for Partner 4:
Full Name of Partner 5:
Street Address for Partner 5:
Phone Number for Partner 5:
Corporation, if applicable
Type of Corporation:
☐ Stock Corporation ☐ Tax Exempt Nonstock Corporation ☐ Close Corporation
Type of Corporation: ☐ For Profit ☐ Non-Profit
Date of Charter:
Date of Articles of Incorporation:
Non-Maryland Corporation: If this is a corporation formed in a State or territory outside the State of Maryland (including in Washington DC, Puerto Rico, Guam, and the US Virgin Islands) or in another country, where was the corporation formed?
Name of Corporation:
Street Address of the Principal Office:
City, State, Zip Code:
Business Email of Principal Office:
Business Phone:
Business Fax:
Name of Resident Agent:
Street Address:
City, State, Zip Code:
Business Email:
Business Phone:
Business Fax:
Enter the full name, street address, city, state, zip code, and business phone number for the Director, President, Secretary, and Treasurer.
Full Name of Director:
Street Address of Director:
Phone Number of Director:
Full Name of President:
Street Address of President:
Phone Number of President:
Full Name of Secretary:
Street Address of Secretary:
Phone Number of Secretary:
Full Name of Treasurer:
Street Address of Treasurer:
Phone Number of Treasurer:

D. Disclosures

1. Does the parent company, owner, or officer currently own or operate a health care facility or agency? ☐ Yes ☐ No If you answered yes, please list the name and type of facility in Section E.

2. Has the parent company, owner, agent, officer, or managerial staff previously owned or operated a health care facility or agency? ☐ Yes ☐ No If you answered yes, please list the name and type of facility in Section E.

3. Has the parent company, owner, or officer had a license to provide care to third parties revoked, suspended, or denied? ☐ Yes ☐ No If you answered yes, please list the name and type of license in Section E.

4. Has the parent company, owner, or officer been convicted of a criminal offense involving any program under Title 18, 19, or 20 of the Social Security Act? ☐ Yes ☐ No If you answered yes, please include details of the conviction in Section E.

5. Has the applicant or anyone with direct or indirect ownership interest in the agency been convicted of a felony? ☐ Yes ☐ No If you answered yes, please include the details of the conviction in Section E.

E. Additional Information

Use this space to clarify any of your responses. Attach additional sheets, as needed.

F. Attestation

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 Maryland Department of Health. In addition, knowingly and willfully failing to fully and accurately disclose the requested information may result in the denial of a request to become licensed or, where the entity already is licensed, a revocation of that license.

I certify that the agency hereby attests that it is in compliance with the federal Civil Rights Act of 1964; the Rehabilitation Act of 1973; the American with Disabilities Act of 1990; and the Drug Free Workplace Act of 1988.

I certify that this applicant is in compliance with all applicable federal, State, and local laws and regulations, including the State administrative and procedural requirements governing nursing referral service agencies in COMAR 10.07.07.

I understand that a licensee may not, under any circumstances, transfer or reassign its nursing referral service agency license to another person. I understand that if the agency ceases to operate for any reason, the license is void and the licensee shall immediately return the license to OHCQ. See COMAR 10.07.07.06.

The signature of an owner, member, partner, or officer is required below.
Full Name of Applicant:
Title of Applicant:
Signature of Applicant:
Date: