DHMH Form AC.APP.1.1 (9/13)

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AMBULATORY CARE APPLICATION FOR LICENSURE

Chier of Nation, Clare chealty

APPLICATION	FOK LIL	ENSURE	- 14 s	.c .a .?		
1. GENERAL INFORMATION			•			•
SELECT ONE TYPE OF LICENSE (only one agency type may be app	lied for on ea	ch application)			***************************************	•
AGENCY TYPE		CODE OF MARYL REGULATIONS (CA		LICEN	SE DURATION	
Ambulatory Surgery Center		10.05	JIVINI I		3 years	•
Birthing Center	·	10.05	· •	•••	3 years	
Comprehensive Outpatient Rehabilitation Facility		10.07.18				
☐ . End Stage Renal Disease Provider		10.05	÷		1 year 3 years	
Home Health Agency	:	10.07.10	Ť			
Hospice Agency		10.07.21	. 1		1 year	
: Mejor Medical Equipment Provider		10.05	į		3 years	
Residential Service Agency (RSA) - Others	. !	10.07.05	!		3 years	
RSA - Skilled Nursing and Aldes Only		10.07.05			1 year	
Surgical Abortion Facility					1 year	
CHECK TYPE OF APPLICATION		10,12,01	i		3 years	
☐ Initial SQ Renewal ☐ Other C	Changes (s	pecify)				
LEGAL AGENCY NAME	TRADING	NAME (DBA)				
Plunned Parenthood of Mary	land)				
			FAX NUN	BER .		
	1		410-1	576	-7600	
BUSINESS ADDRESS (physical tocalion)	MAILING	DDRESS (if different)				
330 NOVAN HOWARD ST	100/255					
אטוווסבת, סותבנו	NUMBER,	SIREET				
Baltimore STATE ZIP 21201	CITY		STATE	ZIP		,
countral timore City	LICENSE N	IUMBER (If applicable)	SADO	0000	5 10/	24/
TOTAL OF FIGURIATION		at the military of a	1111101110	MBER	·	- 1
Ø Ms. □ Mr. □ Mrs		<i>11-994-(</i>	<u> 432</u>			
BUSINESS HOURS (In HH:MM format)			l	. 1		
FROM: SUNDAY MONDAY TUESDAY	WEDNESD		FRIDA	<u>Y</u>	SATURDAY	
10.008	3!30		8:30		8:30A	زاحار
	4:00	P 14:00P	4:0	20	4:00p /	3rd
2. FEES		·		-	, ,	
To determine the amount of the non-refundable license for	ee and acc	epted methods of p	ayment, r	efer to	he	
instruction guide.			,,			
FEE ATTACHED? 💢 Yes			•			
FOR OFFICE USE ONLY					,	
INITIALS DATE NIN NIZ	AMOUNT	AKO, , , a I	CHECKON	MHED	7	
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DATE OF CHECK & BANK I A TO CO	n 10					
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3. OWNERSHIP (Type of SOLE PROPRIETOR	 	PARTNERSH	ID	IV co	RPORATIO	N
NAME			ADDRESS			
THURST PARTIE		mo, Ini				SI Baltimon
NAME(S), TIT	LE(8), AND ADDR	ESS(ES) OF PAR (Altech additio	TNER(S) AND PER nel pages if needed	CENTAGE OWNE !.)	D IF 2% OR I	MORE
NAME AND TITLE			ADDRE	SS		PERCENTAGE OWNED

F CORPORATION: DATE OF INCORPORATION	1-14-10	18/1	FEIN NUMBER			
VÁÍ			DUONE NEW MARK		CELL NUM	BER
ADDRESS (number, street)	ald St		Chalty	nore	STATE	21201
330 N. HW	WEN OI		1110000	1001		
L BACKGROUND						
BACKGROUND Has any owner, officer DHMH within the last fi	, director, agen ve years? [文] i	No Yes (e)	al staff had a lic (plain)	ense revoked,	suspended,	or denied by the
BACKGROUND Has any owner, officer DHMH within the last file. Does the parent comp facility/agency licensec	, director, agent ve years? \(\) i any, owner, age or surveyed by	ont, officer, or m	al staff had a lic (plain) anagerial staff o	ense revoked, own or operate (explain)	suspended, any other h	or denied by the
BACKGROUND Has any owner, officer DHMH within the last file. Does the parent comp	, director, agent ve years? [X] if any, owner, age or surveyed by WEN 100 ests that it is in	ant, officer, or my the OHCQ? [OCC. 929 compliance with	ial staff had a lic (plain) lanagerial staff c ☐ No ☑ Yes / /	ense revoked, own or operate (explain) A.M.A.U.	suspended, any other h	ealth care M.D. 21461
BACKGROUND Has any owner, officer DHMH within the last file. Does the parent comp facility/agency licensed The agency hereby att 1973; The Americans v (explain)	i, director, agent ve years? [X] if any, owner, age or surveyed by WY UN TO ests that it is in with Disabilities if	ant, officer, or ment, or managents, o	al staff had a lickplain) anagerial staff o No Yes WYS The Civil Right The Drug Free gerial staff been	ense revoked, own or operate (explain) A. N. C. B. Act of 1964; Workplace Ac	any other h	ealth care M.O 21461 Illitation Act of X Yes \ No
BACKGROUND Has any owner, officer DHMH within the last file. Does the parent comp facility/agency licensed	i, director, agent ve years? \(\) i any, owner, age or surveyed by \(\) \(\	ant, officer, or ment, or managents, o	al staff had a lickplain) anagerial staff of the Civil Right The Civil Right The Drug Free	ense revoked, own or operate (explain) A. N. C. B. Act of 1964; Workplace Ac	any other h	or denied by the ealth care M.O 21461 Illitation Act of X.Yes \(\) No
Has any owner, officer DHMH within the last file. Does the parent comp facility/agency licensed 12 14 177 14 12 The agency hereby att 1973; The Americans we (explain) Have the owners, office program under Title 18 WORKERS' COMPENSION YOU have any employed.	any, owner, age or surveyed by with Disabilities	ant, officer, or ment, or ment	ial staff had a lic (plain) lanagerial staff of the Divid Right In The Civil Right In The Drug Free gerial staff been y Act?	ense revoked, own or operate (explain) B Act of 1964, own workplace Act of act	any other h	ealth care M.O 21461 Illitation Act of X Yes \ No
Has any owner, officer DHMH within the last file. Does the parent comp facility/agency licensed The agency hereby att 1973; The Americans v (explain) Have the owners, office program under Title 18 WORKERS' COMPEN- TO you have any employed you enswered YES pro	any, owner, age or surveyed by with Disabilities with Disabilities of 19, or 20 of the safe of the saf	nt, officer, or me the OHCQ? [OC 929 compliance with Act of 1990; and gents, or manage Social Security.]	ial staff had a lic (plain) lanagerial staff of No X Yes W/ St St In The Civil Righ of The Drug Free gerial staff been y Act? X No	ense revoked, own or operate (explain) the Act of 1964; Workplace Act convicted of a Yes	any other h	ealth care M.O 21461 Illitation Act of X Yes \ No
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TO:						· · · · · · · · · · · · · · · · · · ·
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NUMBER OF OPERATING/PR	OCEDURE ROOMS		NAME OF MEDIC		The state of the s	<u> </u>
ACCREDITED	ACCREDITING AGEN	CY			DATE OF ACCRED	TATION
Yes No						
and/or certificate DEEMED STATUS	DEEMING AGENCY		· · · · · · · · · · · · · · · · · ·	,	DITT OF BETTER	
☐ Yes ☐ No	DEEMING AGENCY				DATÉ OF DEEMED	STATUS
If yes provide a copy of letter and/or cartificate						
IDENTIFY ALL SPECIALTIES P						
Cardiovascular Colon and Rectal	Neurological OB/GYN		Otolaryngo Pain Mana		Urology Other (specif	<i>.</i>
Endoscopy	Ophthalmology	,	Plastic Sur		Cities (sheris	y)
GI Procedures	│		Podiatric	a <i>)</i>		
☐ General	☐ Onhopedic		Thoracic			
Lower Gi Procedures IDENTIFY ALL MAJOR MEDICA	Other GI Proce	dures	Upper GI			
Cardiac Catheterization E	it equipment officize Equipment Quantit			ERY CENTER Sonance image	or Quantity:	
Computer Tomography E	quipment Quantil	y:	Lithotripter	ACTION OF THE STREET	Quantity:	
Rediation Therapy Equipr	nent Quantit	<u>y:</u>		······································	***************************************	
7. BIRTHING CENTER		·····	····			
NAME OF MEDICAL DIRECTOR	•		NAME OF DIREC	TOR OF MIDWIF	ERY SERVICES	
8. COMPREHENSIVE OU	TPATIENT REHABIL	LITATION	FACILITY	***************************************		
DATE OF ACCREDITATION BY ACCREDITATION OF REHABIL	THE COMMISSION ON		NAME OF MEDIC	AL DIRECTOR		
ACCREDITATION OF REMABILI	ITATION PACILITIES					
Provide a copy of letter and/or ce						
CORE SERVICES PROVIDED Physical Therapy		RVICES PRO		I I'm mank		
Physician		sed Practic pational Th			stered Nurse bilitation Counseld	
Psychological	Ortho		erati		iratory Therapist	זר
☐ Social	Prost				ch Language Path	nlogist
9, END STAGE RENAL DI			——————————————————————————————————————		THE PROPERTY OF THE PARTY OF TH	viosiot .
DIALYSIS SERVICES PROVIDE				······································		***************************************
HEMODIALYSIS	HOME	TRAINING -	HEMODIALYSI6/PI	ERITONEAL DIA	LYSIS	
PERITONEAL DIALYSIS	L-J HOME	SUPPORT -	HEMODIALYSIS/PI	ERITONEAL DIA	LY8IS	
L TRANSPLANTATION IS REUSE PRACTICED	ISOLATION ROOM		NOCTURNAL DIAL	VOID T	PAOK LIN OFFICEA	200
☐ Yes ☐ No	☐ Yes ☐ No		Yes No) "	BACK-UP GENERAT	CK
NUMBER OF DIALYSIS STATIO	NS AT THIS LOCATION		<u>NUMBER OF STAT</u> NAME OF MEDICA			***************************************
DO YOU PROVIDE KIDNEY DIA	LYSIS SERVICES IN A N	IURSING FAC	CILITY OR SKILLED	NURSING FAC	IIITY2 No [Vac /liet
facility names)					لـــا ١١٥٠ لـــا ١٠٠٠	. on fliat
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OHMH Form AC.APP. 1.1 (9/13)			•		-	
· · · • · · · · · · · · · · · · · · · ·						3

10. HOME HEALTH								
NAME AND ADDRESS O	F PARENT	AGEN	ICY IF DIFFE	RENT FROM	LICENSED A	GENCY		· · · · · · · · · · · · · · · · · · ·
ACCREDITED Yes No If yes provide a copy of let and/or certificate		ACCREDITING AGENCY					DATE OF ACC	REDITATION
DEEMED STATUS Yes No If yes provide a copy of let and/or certificate	iter		3 AGENCY				DATE OF DEE	VIED STATUS
PATIENT POPULATION(\$ Adult Maternal/Child He			Pedia Psyc	atric hiatric		Othe	ır (list)	
		SEF	RVICE PROVI		V A			
SERVICES	DIRECTL		THROUGH CONTRACT	DIRECTL THROU CONTRA	GH	CONTR	CTOR'S NAME	
SKILLED NURSING		_						
HOME HEALTH AIDES PHYSICAL THERAPY				┞┈╞╣				
SPEECH LANGUAGE PATHOLOGY								
OCCUPATIONAL THERAPY								
MEDICAL SOCIAL SERVICES					······			
INFUSION SERVICES LIST OTHER								
SERVICES								
NUMBER OF UNDUPLICATION OF THE PROPERTY OF THE	ATEO ADMI	SSION	S FOR THE	LAST	NAME OF N	iursing supervisc	R ,	
NAME OF SERVICE DIRE	CTOR		· · · · · · · · · · · · · · · · · · ·	,	NAME OF S	ERVICE DIRECTOR (ESIGNEE	
11. HOSPICE AGEN								
TYPE OF AGENCY (General		imited					
JURISDICTIONS/COUNTE Cacil Charles Do Cougen Anne's Some	1861 St. 1	Marys	LI FOIDOT L	. Washington	Ballimore Howard Wicomico	City Baitimore Count Kent Montgomed Worcester	y ☐ Calvert ☐ · y ☐ Prince Georg	Caroline Carroll e's
DOES THE AGENCY OPE		n Hos	PICE HOUSE	8?			NUMBE	R OF HOUSES
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DOES THE AGENCY OPE			E-OWNED IN IRE86	PATIENT U	NIT? LI NO	YES (list be) PHONE NUMB		BER OF BEDS
	·							
								77***********************************
DHMH Form ACAPP.1.1 (9/13)								4

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ACCREDITED ACCREDITING AGENC Yes No If yes provide a copy of letter and/or certificate	CY		DATE OF ACCREDITATION
DEEMED STATUS Yes No if yes provide a copy of letter and/or certificate			DATE OF DEEMED STATUS
NAME OF DIRECTOR		AME OF MEDICAL DIRECT	OR
12. MAJOR MEDICAL EQUIPMENT PROVIDE	R		
IDENTIFY ALL MAJOR MEDICAL EQUIPMENT UTILIZED		_ 1	
EQUIPMENT TYPE	NUMBER O EQUIPMEN	•	(ASC, HOSPITAL, ETC)
CARDIAC CATHETERIZATION EQUIPMENT			
COMPUTER TOMOGRAPHY EQUIPMENT			
LITHOTRIPTER			
RADIATION THERAPY EQUIPMENT			
MAGNETIC RESONANCE IMAGER			
IS ANY OF THE ABOVE EQUIPMENT OPERATED AS A vehicles involved)	MOBILE UNIT	NO YES (list t	he equipment and number of
NAME OF MEDICAL DIRECTOR	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~		
14. RSA - OTHERS			
HOME CARE SERVICES TO BE PROVIDED (check all the			
Durable Medical Equipment Durable Medical Equipment w/ Oxygen		Social Services	Skilled Nursing
		tional Therapy	1 Shoorh Thorony
			Speech Therapy
Intravenous or Related Therapies		Therapy	Ventilator Services
Intravenous or Related Therapies CATEGORY			
☐ Intravenous or Related Theraples CATEGORY ☐ For Profit ☐ Non Profit	Physica		Ventilator Services
☐ Intravenous or Related Therapies CATEGORY ☐ For Profit ☐ Non Profit IF DME, ACCREDITING ☐ Yes ☐ No	Physica		
☐ Intravenous or Related Therapies CATEGORY ☐ For Profit ☐ Non Profit IF DME, ACCREDITED ☐ IF DME, ACCREDITING ☐ Yes ☐ No If yes provide a copy of letter	Physica		Ventilator Services
☐ Intravenous or Related Therapies CATEGORY ☐ For Profit ☐ Non Profit IF DME, ACCREDITED ☐ IF DME, ACCREDITING ☐ Yes ☐ No If yes provide a copy of letter and/or certificate	Physical Phy		Ventilator Services
Intravenous or Related Therapies CATEGORY For Profit Non Profit IF DME, ACCREDITING Yes No If yes provide a copy of letter	Physical Phy		Ventilator Services
☐ Intravenous or Related Therapies CATEGORY ☐ For Profit ☐ Non Profit IF DME, ACCREDITED ☐ IF DME, ACCREDITING ☐ Yes ☐ No If yes provide a copy of letter and/or certificate 15. RSA - SKILLED NURSING & AIDES ONLY HOME CARE SERVICES TO BE PROVIDED (check only	AGENCY	Therapy	Ventilator Services
☐ Intravenous or Related Therapies CATEGORY ☐ For Profit ☐ Non Profit IF DME, ACCREDITED ☐ IF DME, ACCREDITING ☐ Yes ☐ No If yes provide a copy of letter and/or certificate 15. RSA - SKILLED NURSING & AIDES ONLY HOME CARE SERVICES TO BE PROVIDED (check only of Level One: RN supervision of Aides without	AGENCY one level of car medication r	Therapy	Ventilator Services
☐ Intravenous or Related Therapies CATEGORY ☐ For Profit ☐ Non Profit IF DME, ACCREDITED ☐ IF DME, ACCREDITING ☐ Yes ☐ No If yes provide a copy of letter and/or certificate 15. RSA - SKILLED NURSING & AIDES ONLY HOME CARE SERVICES TO BE PROVIDED (check only of Level One: RN supervision of Aides without ☐ Level Two: RN supervision of Aides with me	AGENCY one level of our medication r dication mar	Therapy a) nanagement agement	Ventilator Services IF DME, DATE OF ACCREDITATION
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☐ Intravenous or Related Therapies CATEGORY ☐ For Profit ☐ Non Profit IF DME, ACCREDITED ☐ IF DME, ACCREDITING ☐ Yes ☐ No If yes provide a copy of letter and/or certificate 15. RSA - SKILLED NURSING & AIDES ONLY HOME CARE SERVICES TO BE PROVIDED (check only ☐ Level One: RN supervision of Aides without ☐ Level Two: RN supervision of Aides with me ☐ Level Three: Complex care provided by RN, Trach Care, Vent Management, Intravenous	AGENCY One level of car medication r dication mar LPN and Rh or Related 1	s) nanagement agement supervision of Aides (e	Ventilator Services IF DME, DATE OF ACCREDITATION .g. Wound Care, Tube Feeding,
☐ Intravenous or Related Therapies CATEGORY ☐ For Profit ☐ Non Profit IF DME, ACCREDITED ☐ IF DME, ACCREDITING ☐ Yes ☐ No If yes provide a copy of letter and/or certificate 15. RSA - SKILLED NURSING & AIDES ONLY HOME CARE SERVICES TO BE PROVIDED (check only ☐ Level One: RN supervision of Aides without ☐ Level Two: RN supervision of Aides with me ☐ Level Three: Complex care provided by RN, Trach Care, Vent Management, Intravenous	AGENCY One level of car medication r dication mar LPN and Rh or Related 1	a) nanagement agement supervision of Aides (e	Ventilator Services IF DME, DATE OF ACCREDITATION .g. Wound Care, Tube Feeding,
☐ Intravenous or Related Therapies CATEGORY ☐ For Profit ☐ Non Profit IF DME, ACCREDITED ☐ Yes ☐ No If yes provide a copy of letter and/or certificate 15. RSA - SKILLED NURSING & AIDES ONLY HOME CARE SERVICES TO BE PROVIDED (check only of Level One: RN supervision of Aides without ☐ Level Two: RN supervision of Aides with me ☐ Level Three: Complex care provided by RN, ☐ Trach Care, Vent Management, Intravenous CATEGORY ☐ LOST THE TYPE(S) OF ☐ For Profit ☐ Non Profit 16. SURGICAL ABORTION FACILITY	Physical Phy	i Therapy inanagement agement supervision of Aides (e heraples, etc.) are to be provided by y	Ventilator Services IF DME, DATE OF ACCREDITATION .g. Wound Care, Tube Feeding,
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Intravenous or Related Therapies CATEGORY	Physical Phy	a) nanagement agement supervision of Aides (e heraples, etc.) NRE TO BE PROVIDED BY Y mat) EDNESDAY THURSDAY B': 300	J Ventilator Services IF DME, DATE OF ACCREDITATION .g. Wound Care, Tube Feeding, OUR AGENCY FRIDAY SATURDAY 8:30
Intravenous or Related Therapies CATEGORY	Physical Phy	I Therapy I Therapy I Therapy I Supervision of Aides (elemants) I Supervision of Aides (elemants) I Supervision of Aides (elemants) I THURSOA I THU	J Ventilator Services IF DME, DATE OF ACCREDITATION .g. Wound Care, Tube Feeding, OUR AGENCY FRIDAY SATURDAY 8:30

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ACCREDITED Yes No If yes provide a copy of letter and/or certificate	Planned Pare	othood Fede	ration	DATE OF	accreditation 512 - 12/261
IDENTIFY ALL MAJOR MEDICA Cardiac Catheterization E Computer Tomography E Radiation Therapy Equipr	quipment Quantity: quipment Quantity:	☐ Magnetic Reso☐ Lithotripter	nance Imag		Quantity: Quantity:
17. AFFIDAVIT					
application are true. I unde prosecution, civil money po- knowingly and willfully faille request to become license I certify that this agency is Maryland Regulations (CO	penalties of perjury and uporstand that the falsification of enalties, and/or the revocation go to fully and accurately distributed or, where the entity alread in compliance with administration of the control of the	of an application for a con of any license issue close the requested in y is licensed, a revoca ative and procedural	license may ed to me by nformation of ation of that requiremen	y subject n the DHMI may result license. Is pertaini	ne to criminal H. In addition, In denial of a ing to the Code of
hat written notice will be g	ven before the effective date	e of the change.		-go, u.	.e operation, and
•	hat I am over the age of 21 a		•	•	
	e in more than one applican	t's name, each applic	ant's signal	ture is requ	uired.
Governing Regulations: Ambulatory Surgery Center - Birthing Center - COMAR 10 Comprehensive Outpetlent R 10.07.18 End Stege Renal Disease Pr Home Health Agency - COM	.05 eheblikation Facility COMAR ovider COMAR 10,05	Hospice Agency Major Medical Ec Residential Servi COMAR 10,07,05 Surgical Abortion	juipment Prov ce Agencies - ce Agencies - ;	ider - COM <i>i</i> - Others - Ci - Skilled Nur	OMAR 10.07.05 sing and Aides Only
		VP of Clair	OOB	DATE	5/15
GIGNATURE OF APPLICANT		TITLE		DATE	
				UALE	
BIGNATURE OF APPLICANT		TITLE		DATE	
18. BRANCH OFFICES (re	fer to definition in instruction	guide prior to comple	eting this se	ection)	
ICENSED NAME		LICENSE NUMBER			
OCES THE AGENCY OPERATE	ANY BRANCH OFFICES?	I lo ☐ Yes (list all be	low)		
	ADDRESS	CITY	STATE	ZIP	PHONE NUMBER
					
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