STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE (DHMH)
OFFICE OF HEALTH CARE QUALITY (OHCQ)

SEP 1 2015

Form Approved 3/31/03
DHMH Form AC.APP.1.1

AMBULATORY CARE
APPLICATION FOR LICENSURE

Office of Health Care Quality

1. GENERAL INFORMATION

SELECT ONE TYPE OF LICENSE (only one agency type may be applied for on each application)

	AGENCY TYPE	CODE OF MARYLAND REGULATIONS (COMAR)	LICENSE DURATION
☐	Ambulatory Surgery Center	10.05	3 years
☐	Birthing Center	10.05	3 years
☐	Comprehensive Outpatient Rehabilitation Facility	10.07.18	1 year
☐	End Stage Renal Disease Provider	10.05	3 years
☐	Home Health Agency	10.07.10	1 year
☐	Hospice Agency	10.07.21	3 years
☐	Major Medical Equipment Provider	10.05	3 years
☐	Residential Service Agency (RSA) – Others	10.07.05	1 year
☐	RSA – Skilled Nursing and Aides Only	10.07.05	1 year
☒	Surgical Abortion Facility	10.12.01	3 years

CHECK TYPE OF APPLICATION
☐ Initial ☒ Renewal ☐ Other Changes (specify)

LEGAL AGENCY NAME: Planned Parenthood of Maryland
TRADING NAME (DBA):
[redacted]
FAX NUMBER: 410-576-7600

BUSINESS ADDRESS (physical location): 330 North Howard St
NUMBER, STREET
CITY: Baltimore STATE: MD ZIP: 21201
COUNTY: Baltimore City

MAILING ADDRESS (if different)
NUMBER, STREET
CITY STATE ZIP

LICENSE NUMBER (if applicable): SA000005 10/24/18
NAME OF ADMINIS[redacted]
☒ Ms. ☐ Mr. ☐ Mrs
AFTER HOURS/EMERGENCY CONTACT NUMBER: 877-994-6432

BUSINESS HOURS (in HH:MM format)

	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
FROM:	/	10:00a	/	8:30a	8:30a	8:30a	5:30a (1st; 3rd Sat)
TO:		4:00p		4:00p	4:00p	4:00p	4:00p

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

FOR OFFICE USE ONLY

INITIALS [redacted]	DATE 7/27/15	AMOUNT PAID $1,500.00	CHECK NUMBER 09758
DATE OF CHECK 7/23/15	BANK M&T Bank		

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

☐ SOLE PROPRIETORSHIP ☐ PARTNERSHIP ☒ CORPORATION

NAME	ADDRESS
Planned Parenthood of MD, Inc	330 N. Howard St, Baltimore

NAME(S), TITLE(S), AND ADDRESS(ES) OF PARTNER(S) AND PERCENTAGE OWNED IF 2% OR MORE
(Attach additional pages if needed.)

NAME AND TITLE	ADDRESS	PERCENTAGE OWNED

IF CORPORATION:

DATE OF INCORPORATION	FEIN NUMBER	
1-14-1986	[redacted]	
NA[redacted]	[redacted]	CELL NUMBER
ADDRESS (number, street)	CITY	STATE / ZIP
330 N. Howard St	Baltimore	MD / 21201

4. BACKGROUND

1. Has any owner, officer, director, agency, or managerial staff had a license revoked, suspended, or denied by the DHMH within the last five years? ☒ No ☐ Yes (explain)

2. Does the parent company, owner, agent, officer, or managerial staff own or operate any other health care facility/agency licensed or surveyed by the OHCQ? ☐ No ☒ Yes (explain)
Planned Parenthood 929 West St Annapolis MD 21401

3. The agency hereby attests that it is in compliance with The Civil Rights Act of 1964; The Rehabilitation Act of 1973; The Americans with Disabilities Act of 1990; and The Drug Free Workplace Act of 1988. ☒ Yes ☐ No (explain)

4. Have the owners, officers, directors, agents, or managerial staff been convicted of a criminal offense involving any program under Title 18, 19, or 20 of the Social Security Act? ☒ No ☐ Yes

5. WORKERS' COMPENSATION

Do you have any employees? ☒ Yes ☐ No

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

POLICY NUMBER	BINDER NUMBER	
RSC C481258762		
INSURANCE COMPANY	EFFECTIVE DATE	EXPIRATION DATE
Marsh USA Inc Include copy of insurance information.	1-1-2015	1-1-2016

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

6. AMBULATORY SURGERY CENTER

DAYS AND HOURS THE OFFICE MANAGER IS ON-SITE (in HH:MM format)

	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
FROM:							

TO:							

BACK-UP GENERATOR ☐ Yes ☐ No

DAYS OR IS USED ☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday

NUMBER OF OPERATING/PROCEDURE ROOMS

NAME OF MEDICAL DIRECTOR

ACCREDITED ☐ Yes ☐ No
If yes provide a copy of letter and/or certificate

ACCREDITING AGENCY

DATE OF ACCREDITATION

DEEMED STATUS ☐ Yes ☐ No
If yes provide a copy of letter and/or certificate

DEEMING AGENCY

DATE OF DEEMED STATUS

IDENTIFY ALL SPECIALTIES PROVIDED

☐ Cardiovascular	☐ Neurological	☐ Otolaryngology	☐ Urology
☐ Colon and Rectal	☐ OB/GYN	☐ Pain Management	☐ Other (specify)
☐ Endoscopy	☐ Ophthalmology	☐ Plastic Surgery	
☐ GI Procedures	☐ Oral	☐ Podiatric	
☐ General	☐ Orthopedic	☐ Thoracic	
☐ Lower GI Procedures	☐ Other GI Procedures	☐ Upper GI	

IDENTIFY ALL MAJOR MEDICAL EQUIPMENT UTILIZED IN THE AMBULATORY SURGERY CENTER

☐ Cardiac Catheterization Equipment	Quantity:	☐ Magnetic Resonance Imager	Quantity:
☐ Computer Tomography Equipment	Quantity:	☐ Lithotripter	Quantity:
☐ Radiation Therapy Equipment	Quantity:		

7. BIRTHING CENTER

NAME OF MEDICAL DIRECTOR

NAME OF DIRECTOR OF MIDWIFERY SERVICES

8. COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY

DATE OF ACCREDITATION BY THE COMMISSION ON ACCREDITATION OF REHABILITATION FACILITIES

Provide a copy of letter and/or certificate

NAME OF MEDICAL DIRECTOR

CORE SERVICES PROVIDED
- ☐ Physical Therapy
- ☐ Physician
- ☐ Psychological
- ☐ Social

OTHER SERVICES PROVIDED

☐ Licensed Practical Nurse	☐ Occupational Therapy	☐ Orthotist
☐ Prosthetist	☐ Registered Nurse	☐ Rehabilitation Counselor
☐ Respiratory Therapist	☐ Speech Language Pathologist	

9. END STAGE RENAL DISEASE PROVIDER

DIALYSIS SERVICES PROVIDED
- ☐ HEMODIALYSIS
- ☐ PERITONEAL DIALYSIS
- ☐ TRANSPLANTATION
- ☐ HOME TRAINING - HEMODIALYSIS/PERITONEAL DIALYSIS
- ☐ HOME SUPPORT - HEMODIALYSIS/PERITONEAL DIALYSIS

IS REUSE PRACTICED ☐ Yes ☐ No

ISOLATION ROOM ☐ Yes ☐ No

NOCTURNAL DIALYSIS ☐ Yes ☐ No
NUMBER OF STATIONS

BACK-UP GENERATOR ☐ Yes ☐ No

NUMBER OF DIALYSIS STATIONS AT THIS LOCATION

NAME OF MEDICAL DIRECTOR

DO YOU PROVIDE KIDNEY DIALYSIS SERVICES IN A NURSING FACILITY OR SKILLED NURSING FACILITY? ☐ No ☐ Yes (list facility names)

10. HOME HEALTH AGENCY

NAME AND ADDRESS OF PARENT AGENCY IF DIFFERENT FROM LICENSED AGENCY

ACCREDITED ☐ Yes ☐ No If yes provide a copy of letter and/or certificate	ACCREDITING AGENCY	DATE OF ACCREDITATION
DEEMED STATUS ☐ Yes ☐ No If yes provide a copy of letter and/or certificate	DEEMING AGENCY	DATE OF DEEMED STATUS

PATIENT POPULATION(S) SERVED

☐ Adult ☐ Maternal/Child Health ☐ Pediatric ☐ Psychiatric ☐ Other (list)

SERVICES	SERVICE PROVIDED: DIRECTLY	THROUGH CONTRACT	DIRECTLY & THROUGH CONTRACT	CONTRACTOR'S NAME
SKILLED NURSING	☐	☐	☐	
HOME HEALTH AIDES	☐	☐	☐	
PHYSICAL THERAPY	☐	☐	☐	
SPEECH LANGUAGE PATHOLOGY	☐	☐	☐	
OCCUPATIONAL THERAPY	☐	☐	☐	
MEDICAL SOCIAL SERVICES	☐	☐	☐	
INFUSION SERVICES	☐	☐	☐	
LIST OTHER SERVICES	☐	☐	☐	

NUMBER OF UNDUPLICATED ADMISSIONS FOR THE LAST FISCAL YEAR	NAME OF NURSING SUPERVISOR
NAME OF SERVICE DIRECTOR	NAME OF SERVICE DIRECTOR DESIGNEE

11. HOSPICE AGENCY

TYPE OF AGENCY ☐ General ☐ Limited

JURISDICTIONS/COUNTIES SERVED ☐ Allegany ☐ Anne Arundel ☐ Baltimore City ☐ Baltimore County ☐ Calvert ☐ Caroline ☐ Carroll ☐ Cecil ☐ Charles ☐ Dorchester ☐ Frederick ☐ Garrett ☐ Harford ☐ Howard ☐ Kent ☐ Montgomery ☐ Prince George's ☐ Queen Anne's ☐ Somerset ☐ St. Mary's ☐ Talbot ☐ Washington ☐ Wicomico ☐ Worcester

DOES THE AGENCY OPERATE/OWN HOSPICE HOUSES? ☐ NO ☐ YES (list below)

UNIT ADDRESS	PHONE NUMBER	NUMBER OF HOUSES / NUMBER OF BEDS

DOES THE AGENCY OPERATE A HOSPICE-OWNED INPATIENT UNIT? ☐ NO ☐ YES (list below)

UNIT ADDRESS	PHONE NUMBER	NUMBER OF BEDS

ACCREDITED ☐ Yes ☐ No If yes provide a copy of letter and/or certificate	ACCREDITING AGENCY	DATE OF ACCREDITATION
DEEMED STATUS ☐ Yes ☐ No If yes provide a copy of letter and/or certificate	DEEMING AGENCY	DATE OF DEEMED STATUS
NAME OF DIRECTOR	NAME OF MEDICAL DIRECTOR	

12. MAJOR MEDICAL EQUIPMENT PROVIDER

IDENTIFY ALL MAJOR MEDICAL EQUIPMENT UTILIZED

	EQUIPMENT TYPE	NUMBER OF EQUIPMENT	SETTING (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 MOBILE UNIT? ☐ NO ☐ YES (list the equipment and number of vehicles involved)

NAME OF MEDICAL DIRECTOR

14. RSA - OTHERS

HOME CARE SERVICES TO BE PROVIDED (check all that apply)

☐ Durable Medical Equipment	☐ Medical Social Services	☐ Skilled Nursing
☐ Durable Medical Equipment w/ Oxygen	☐ Occupational Therapy	☐ Speech Therapy
☐ Intravenous or Related Therapies	☐ Physical Therapy	☐ Ventilator Services

CATEGORY ☐ For Profit ☐ Non Profit

IF DME, ACCREDITED ☐ Yes ☐ No If yes provide a copy of letter and/or certificate	IF DME, ACCREDITING AGENCY	IF DME, DATE OF ACCREDITATION

15. RSA - SKILLED NURSING & AIDES ONLY

HOME CARE SERVICES TO BE PROVIDED (check only one level of care)

☐ Level One: RN supervision of Aides without medication management
☐ Level Two: RN supervision of Aides with medication management
☐ Level Three: Complex care provided by RN, LPN and RN supervision of Aides (e.g. Wound Care, Tube Feeding, Trach Care, Vent Management, Intravenous or Related Therapies, etc.)

CATEGORY ☐ For Profit ☐ Non Profit	LIST THE TYPE(S) OF COMPLEX CARE TO BE PROVIDED BY YOUR AGENCY

16. SURGICAL ABORTION FACILITY

DAYS AND HOURS THE OFFICE MANAGER IS ON-SITE (in HH:MM format)

	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
FROM:	/	10:00a	/	8:30a	8:30a	8:30a	
TO:	/	4:00p	/	4:00p	4:00p	4:00p	/

BACK-UP GENERATOR ☐ Yes ☒ No

DAYS OR IS USED ☐ Sunday ☒ Monday ☐ Tuesday ☒ Wednesday ☒ Thursday ☒ Friday ☒ Saturday

NUMBER OF OPERATING/PROCEDURE ROOMS 3

NAME OF MEDICAL DIRECTOR [redacted]

ACCREDITED	ACCREDITING AGENCY	DATE OF ACCREDITATION
☒ Yes ☐ No If yes provide a copy of letter and/or certificate	Planned Parenthood Federation	9/2012 - 12/2016

IDENTIFY ALL MAJOR MEDICAL EQUIPMENT UTILIZED

☐ Cardiac Catheterization Equipment	Quantity:	☐ Magnetic Resonance Imager	Quantity:
☐ Computer Tomography Equipment	Quantity:	☐ Lithotripter	Quantity:
☐ Radiation Therapy Equipment	Quantity:		

17. 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 administrative and procedural requirements pertaining to the Code of Maryland Regulations (COMAR) checked below.

I further certify that I will notify the OHCQ 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 21 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.

Governing Regulations:

- ☐ Ambulatory Surgery Center – COMAR 10.05
- ☐ Birthing Center – COMAR 10.05
- ☐ Comprehensive Outpatient Rehabilitation Facility – COMAR 10.07.18
- ☐ End Stage Renal Disease Provider – COMAR 10.05
- ☐ Home Health Agency – COMAR 10.07.10
- ☐ Hospice Agency – COMAR 10.07.21
- ☐ Major Medical Equipment Provider - COMAR 10.05
- ☐ Residential Service Agencies – Others – COMAR 10.07.05
- ☐ Residential Service Agencies – Skilled Nursing and Aides Only – COMAR 10.07.05
- ☒ Surgical Abortion Facility – COMAR 10.12.01

	TITLE	DATE
[redacted]	VP of Clinical Ops	7/15/15
	TITLE	DATE
SIGNATURE OF APPLICANT	TITLE	DATE
SIGNATURE OF APPLICANT	TITLE	DATE

18. BRANCH OFFICES (refer to definition in instruction guide prior to completing this section)

LICENSED NAME	LICENSE NUMBER

DOES THE AGENCY OPERATE ANY BRANCH OFFICES? ☐ No ☐ Yes (list all below)

STREET ADDRESS	CITY	STATE	ZIP	PHONE NUMBER