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

DEC 10 2015

Form Approved 3/31/13
DHMH Form AC.APP.1.1

AMBULATORY CARE
APPLICATION FOR LICENSURE

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: Prince Georges Reproductive Health Services	TRADING NAME (DBA)
E-MAIL ADDRESS: ashleyqrhs@gmail.com	PHONE NUMBER: 301-434-2300 / FAX NUMBER: 301-434-0719
BUSINESS ADDRESS (physical location): 7411 Riggs Road Suite 300	MAILING ADDRESS (if different)
NUMBER, STREET: Hyattsville	NUMBER, STREET
CITY: Hyattsville / STATE: MD / ZIP: 20783	CITY / STATE / ZIP
COUNTY: Prince Georges County	LICENSE NUMBER (if applicable): SA0000017 12/20/15
NAME OF ADMINISTRATOR (Last, First, Middle Initial) ☐ Ms. ☐ Mr. ☑ Mrs. Ashley G. Monktafi	AFTER HOURS/EMERGENCY CONTACT NUMBER: 240-418-3698

BUSINESS HOURS (in HH:MM format)

	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
FROM:	/	8:00	/	800	930	800	730
TO:	/	4:00	/	400	400	400	100

Thursdays and Saturdays Abortion

↓ Patient day ↓ patient day

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

INITIA[redacted]	DATE 12/10/15	AMOUNT PAID $1500.00	CHECK NUMBER 7611
DATE OF CHECK 12/07/15	BANK MT		

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DHMH Form AC.APP.1.1.IN.SA.2

AMBULATORY CARE: SURGICAL ABORTION FACILITY APPLICATION

INSTRUCTIONS FOR COMPLETION

Incomplete applications will be returned. Prior to submitting the application, ensure it includes all required information, related required documentation, and the fee.

APPLICATION FOR LICENSE

Once all required application paperwork and the fee is received, an OHCQ representative will contact your program to schedule a date for an initial State licensure inspection. A State license will be issued based on the results of the on-site inspection.

FEE

The non-refundable application fee is $1,500.

The application fee must be submitted with the application. Make the business check, cashier's check, money order, or personal check payable to: "DHMH." Starter checks will not be accepted.

REQUIRED APPLICATION SECTIONS

General Information
Fees
Ownership
Background
Workers' Compensation
Surgical Abortion Facility
Affidavit

REQUIRED DOCUMENTATION - *INITIAL* APPLICATION

1. **If the facility is accredited, the facility must submit a copy of the accreditation status letter.**
2. Policies and procedures.
3. A written description of the quality assurance program.
4. If your program does not have workers' compensation insurance AND does not have any employees, submit a Letter of Exemption (sole proprietorships or partnerships) or Certificate of Compliance (corporations or LLCs) from the Certificate of Compliance Coordinator at the Workers' Compensation Commission. For information call 410-864-5100 or via e-mail at www.wcc.state.md.us.

CODE OF MARYLAND REGULATIONS (COMAR) 10.12.01

To obtain a copy of the regulations:

A. Visit the Division of State Documents website at www.dsd.state.md.us;
B. Call the Division of State Documents at 410-974-2486 x3876 or 800-633-9657 x3876; or
C. Visit your library (click this link to find the closest location: www.dsd.state.md.us/Depositories.aspx).

QUESTIONS

Please contact 410-402-8040 or visit the OHCQ website at http://dhmh.maryland.gov/ohcq for questions related to the application.

SEND COMPLETED APPLICATION TO:

Ambulatory Care Program
OHCQ
Bland Bryant Building
Spring Grove Hospital Center
55 Wade Avenue
Catonsville, MD 21228

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

☐ SOLE PROPRIETORSHIP	☐ PARTNERSHIP	☑ CORPORATION

NAME	ADDRESS
[redacted]	7411 Riggs Rd #300 Hyattsville MD 20783

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

DEC 10 2015

IF CORPORATION:

DATE OF INCORPORATION	FEIN NUMBER		
01-01-85			
NAME OF PRESIDENT	**PHONE NUMBER**	**CELL NUMBER**	
[redacted]	301-434-2300	[redacted]	
ADDRESS (number, street)	**CITY**	**STATE**	**ZIP**
7411 Riggs Rd #300	Hyattsville	MD	20783

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)
Germantown Reproductive Health Services SA0000001

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	
WCV60887706	199768	
INSURANCE COMPANY	**EFFECTIVE DATE**	**EXPIRATION DATE**
Accident Fund / Feinman Ins.	02/15/15	02/15/16
Include copy of insurance information.		

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	DAYS OR IS USED
☐ Yes ☐ No	☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday
NUMBER OF OPERATIING/PROCEDURE ROOMS	NAME OF MEDICAL DIRECTOR

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

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	OTHER SERVICES PROVIDED	
☐ Physical Therapy	☐ Licensed Practical Nurse	☐ Registered Nurse
☐ Physician	☐ Occupational Therapy	☐ Rehabilitation Counselor
☐ Psychological	☐ Orthotist	☐ Respiratory Therapist
☐ Social	☐ Prosthetist	☐ Speech Language Pathologist

9. END STAGE RENAL DISEASE PROVIDER

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

IS REUSE PRACTICED	ISOLATION ROOM	NOCTURNAL DIALYSIS	BACK-UP GENERATOR
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No NUMBER OF STATIONS	☐ 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	ACCREDITING AGENCY	DATE OF ACCREDITATION
☐ Yes ☐ No If yes provide a copy of letter and/or certificate	DEC 10 2015	
DEEMED STATUS	**DEEMING AGENCY**	**DATE OF DEEMED STATUS**
☐ Yes ☐ No If yes provide a copy of letter and/or certificate	Joint Care Quality	

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:					930		730
TO:					400		100

BACK-UP GENERATOR ☐ Yes ☑ No	DAYS OR IS USED ☐ Sunday ☐ Monday ☐ Tuesday ☐ Wednesday ☑ Thursday ☐ Friday ☑ Saturday
NUMBER OF OPERATIING/PROCEDURE ROOMS 2	NAME OF MEDICAL DIRECTOR [redacted]

ACCREDITED	ACCREDITING AGENCY	DATE OF ACCREDITATION
☑ Yes ☐ No If yes provide a copy of letter and/or certificate	DHMH National Abortion Federation 2015	07-24-13 2011

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

SIGNATURE OF APPLICANT	TITLE	DATE
[redacted]	President	7/20/15
SIGNATURE OF APPLICANT	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