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Office of Health Care Quality

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

Form Approved 07/07/2015
DHMH Form AC.APP.1.0

AMBULATORY CARE APPLICATION FOR LICENSURE

1. GENERAL INFORMATION

CHECK TYPE OF LICENSE

	AGENCY TYPE	CODE OF MARYLAND REGULATIONS (COMAR)	LICENSE DURATION
■	~~Ambulatory Surgery Center~~ Surgical Abortion Facility	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	3 years
☐	RSA – Skilled Nursing and Aides Only	10.07.05	3 years
☐	Cosmetic Surgery Centers	10.12.03	3 years

CHECK TYPE OF APPLICATION

■ Initial ☐ Renewal ☐ Other Changes (specify)

LEGAL AGENCY NAME FEMHEALTH USA, INC	TRADING NAME (DBA) CARAFEM
E-MAIL ADDRESS MELISSA.GRANT@CARAFEM.ORG	PHONE NUMBER 202-530-4160 / FAX NUMBER
BUSINESS ADDRESS (physical location) CARAFEM	MAILING ADDRESS (if different) FEMHEALTH USA, INC
NUMBER, STREET 5530 WISCONSIN AVE	NUMBER, STREET 1156 15TH ST NW, STE 700
CITY CHEVY CHASE / STATE MD / ZIP 20815	CITY WASHINGTON / STATE DC / ZIP 20005
COUNTY Montgomery Co	LICENSE NUMBER (if applicable) 150090 (Laboratory)
NAME OF ADMINISTRATOR (Last, First, Middle Initial) [redacted]	AFTER HOURS/EMERGENCY CONTACT NUMBER [redacted]

BUSINESS HOURS (in HH:MM format)

	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
FROM:			8:30 AM	12:00 PM	8:30 PM	8:30 PM	8:30 AM
TO:			5:30 PM	7:00 PM	5:30 PM	5:30 PM	1:00 PM

2. FEES $1500

To determine the amount of the **non-refundable** license fee and accepted methods of payment, refer to the instruction guide.

FEE ATTACHED? ■ Yes

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

☐ SOLE PROPRIETORSHIP ☐ PARTNERSHIP ■ CORPORATION

NAME FemHealth USA , Inc	ADDRESS 1156 15th St NW, Washington, DC 20005

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
Christopher Purdy : President of FemHealth USA	1156 15th ST NW, Ste 700, Washington, DC 20005	0
Phil Harvey : Founder of DKT International and Population Services International	1156 15th ST NW, Ste 700, Washington, DC 20005	0
Dr. Sara Newmann : ObGyn and assistant clinical professor at UCSF Medical Center	PO Box 0842, 1001 Potrero, 6-D University of California, San Francisco, San Francisco, CA 94110	0
Melissa Grant : Vice President of Health Services of FemHealth USA	1156 15th ST NW, Ste 700, Washington, DC 20005	0
Julie Stewart : Founder of FAMM	1156 15th ST NW, Ste 700, Washington, DC 20005	0

IF CORPORATION:

DATE OF CHARTER	DATE OF INCORPORATION	FEIN NUMBER
	11/14/13	[redacted]

NAME OF PRESIDENT	PHONE NUMBER	CELL NUMBER	
Christopher Purdy : President of FemHealth USA	202-530-4160		
ADDRESS (number, street)	**CITY**	**STATE**	**ZIP**
1156 15th ST NW, Ste 700	Washington	DC	20005

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 a health care facility/agency licensed or surveyed by the OHCQ? ☒ No ☐ Yes (explain)

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, attach a copy of your workers' compensation insurance policy and complete the following:

POLICY NUMBER	BINDER NUMBER	
20100711		
INSURANCE COMPANY	**EFFECTIVE DATE**	**EXPIRATION DATE**
Chesapeake Employers Insurance	06/17/15	06/17/16

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:			08:30 AM	08:30 AM	08:30 AM	08:30 AM	08:30 AM
TO:			05:30 PM	7:30PM	06:00 PM	5:30 PM	01:00 PM

BACK-UP GENERATOR ☐ Yes ☒ No

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

NUMBER OF OPERATIING/PROCEDURE ROOMS	NAME OF MEDICAL DIRECTOR	
1	[redacted]	
ACCREDITED	**ACCREDITING AGENCY**	**DATE OF ACCREDITATION**
☒ Yes ☐ No	National Abortion Federation	5/20/2015
DEEMED STATUS	**DEEMING AGENCY**	**DATE OF DEEMED STATUS**
☐ Yes ☐ No		

IDENTIFY ALL SPECIALTIES PROVIDED

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

IDENTIFY ALL MAJOR MEDICAL EQUIPMENT UTILIZED IN THE AMBULATORY SURGERY CENTER

Equipment	Quantity	Equipment	Quantity
☐ Cardiac Catheterization Equipment	Quantity:	☐ Magnetic Resonance Imager	Quantity:
☐ Computer Tomography Equipment	Quantity:	☐ Lithotripter	Quantity:
☐ Radiation Therapy Equipment	Quantity:	NONE	

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	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. COSMETIC SURGICAL FACILITY

PLEASE CHECK THE BOX **ONLY IF** THE ANSWER TO THE QUESTION IS **"YES"**.

- ☐ The applicant has been convicted of a crime of moral turpitude
- ☐ The applicant held a position as an owner, director, officer in a corporate entity that had its license revoked?
- ☐ Has an individual or corporate applicant consented to surrender a license as a result of a license revocation action?
- ☐ The corporate entity has an owner, director, officer, or other person with substantial interest whose conduct caused the revocation of a prior license?

ACCREDITED	ACCREDITING AGENCY	DATE OF ACCREDITATION
☐ Yes ☐ No		

NAME OF MEDICAL DIRECTOR	NAME OF ADMINISTRATOR

10. 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	ISOLATION ROOM	BACK-UP GENERATOR
☐ Yes ☐ No	☐ Yes ☐ No	☐ 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)

11. HOME HEALTH AGENCY

NAME AND ADDRESS OF PARENT AGENCY IF DIFFERENT FROM LICENSED AGENCY

ACCREDITED ☐ Yes ☐ No	ACCREDITING AGENCY	DATE OF ACCREDITATION
DEEMED STATUS ☐ Yes ☐ No	DEEMING AGENCY	DATE OF DEEMED STATUS

PATIENT POPULATION(S) SERVED
☐ Adult ☐ Pediatric ☐ Other (list)
☐ Maternal/Child Health ☐ Psychiatric

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

12. 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)

NUMBER OF HOUSES

UNIT ADDRESS	PHONE NUMBER	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	ACCREDITING AGENCY	DATE OF ACCREDITATION
DEEMED STATUS ☐ Yes ☐ No	DEEMING AGENCY	DATE OF DEEMED STATUS

NAME OF DIRECTOR	NAME OF MEDICAL DIRECTOR

13. 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
☐ Durable Medical Equipment w/ Oxygen
☐ Intravenous or Related Therapies
☐ Medical Social Services
☐ Occupational Therapy
☐ Physical Therapy
☐ Skilled Nursing
☐ Speech Therapy
☐ Ventilator Services

CATEGORY
☐ For Profit ☐ Non Profit

IF DME, ACCREDITED	IF DME, ACCREDITING AGENCY	IF DME, DATE OF ACCREDITATION
☐ Yes ☐ No		

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

16. 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:

- [x] 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
- [ ] Nursing Referral Service Agency – COMAR 10.07.07
- [ ] Nursing Staff Agencies – COMAR 10.07.03
- [ ] Residential Service Agencies – Others – COMAR 10.07.05
- [ ] Residential Service Agencies – Skilled Nursing and Aides Only – COMAR 10.07.05
- [ ] Cosmetic Surgical Facility – COMAR 10.12.03

SIGNATURE OF APPLICANT	TITLE	DATE
[redacted]	Vice President	3-28-16
SIGNATURE OF APPLICANT	TITLE	DATE
SIGNATURE OF APPLICANT	TITLE	DATE
SIGNATURE OF APPLICANT	TITLE	DATE

FOR OFFICE USE ONLY

INITIALS	DATE	AMOUNT PAID	CHECK NUMBER
DATE OF CHECK	BANK		