



Montgomery County Department of Health and Human Services
Licensure and Regulatory Services

255 Rockville Pike, Suite 100; Rockville, Maryland 20850
Phone: 240-777-3986 Fax: 240-777-3088
www.montgomerycountymd.gov/licensure

HOSPITAL, NURSING HOME, AND DOMICILIARY LICENSE APPLICATION

TODAY'S DATE: _____

New [] ** Renewal [] Change of Owner [] Name Change [] Bed Increase []

Name of Institution: _____ Telephone No: _____

Address of Institution: _____
(Street number, suite number, street name, city, state, and zip code)

Fax No: _____ Email: _____

Owner/Corporation Name: _____ Telephone No. _____

Address of Owner/Corporation: _____
(Street number, suite number, street name, city, state, and zip code)

Federal Tax Identification No: _____ Former Name of Facility (if applicable): _____

Type of Institution (please check one):

Hospital - \$230 [] Nursing Home - \$12.50 per bed [] Domiciliary Care Home - \$10.00 per bed []

Type of Care Provided: _____

Bed Capacity (excluding bassinets): _____ Number of Bassinets: _____

Workers' Compensation Insurance Company Name: _____ Policy/Binder No: _____

Check here [] if this facility is operated by a sole proprietor with no employees, or by members of a partnership or LLC, and a Certificate of Compliance has been obtained. You must submit a copy of the Certificate of Compliance with this application.

EMERGENCY CONTACT INFORMATION

Director or Administrator: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Montgomery County Department of Health and Human Services must be notified when the emergency contact information changes.

** All New Applicants Must Submit the Use and Occupancy Permit from the Department of Permitting Services (240-777-0311).

I hereby certify that the above information is accurate and complete:

Signature of Owner or Agent: _____

Printed Name and Title of Above Signatory: _____

SEE PAGE TWO FOR PAYMENT INFORMATION

Payment Method: Check Money Order Visa Mastercard Make checks or money orders payable to **"Montgomery County, Maryland"**. Cash is not accepted. Credit card payments may be faxed to 240-777-4531 (confidential fax line).

Fee: \$ _____ Credit Card No: _____ Exp. Date: _____ 3 Digit Code: _____

Credit Cardholder's Name: _____ Amount Charged: \$ _____

I agree to pay the indicated total amount according to card issuer agreement:

Cardholder's Signature: _____

FEE SCHEDULE

<u>Type of Facility</u>	<u>Fee</u>
Hospital:.....	\$230.00
Nursing Home:.....	\$12.50/bed
Domiciliary Care Home:.....	\$10.00/bed
Late Application Fee - For all applications received after the license expiration date:.....	\$100.00

All licenses expire one year after date of issuance.

OFFICE USE ONLY

Receipt No: _____

Date Received: _____

Amount Paid: _____

Staff's Initials: _____

Check/Money Order No: _____

MC/VISA Approval Code No.: _____