



**Government of the District of Columbia
 Department of Health
 Health Regulation and Licensing Administration
 Health Care Facilities Division**

**Mailing Address:
 899 North Capitol St., NE, 2nd Floor
 Washington, DC 20002
 Phone: 202-724-8800**

Fees

**Annual\$390.00
 Late\$195.00**

Application for Maternity Center

Under the authority of DC Law 5-48, application is hereby made to operate a facility as indicated below:

1. APPLICATION IS FOR (CHECK ONE):

Type Action		Effective Date of Action
<input type="checkbox"/>	Initial Licensure License Number _____	
<input type="checkbox"/>	Change of licensed operator	
<input type="checkbox"/>	License Renewal	
<input type="checkbox"/>	Change in Number of Birth Rooms	
<input type="checkbox"/>	Name Change	

2. FACILITY IDENTIFICATION

Name of Facility _____		Telephone Number _____	
Street Address _____		FAX Number _____	
City _____	State _____	ZIP _____	
Facility is (Check one) { <input type="checkbox"/> } Owned – Documentation Required { <input type="checkbox"/> } Leased - Bond Required			

3. NUMBER OF BIRTH ROOMS

Total Number of Birth Rooms _____	Number of deliveries in the previous Fiscal Year _____
FY _____	# of Deliveries _____

4. SERVICE PROVIDED

Identify below all services provided by the center. Write a (D) by each service that is provided directly and a (C) by each service provided by contract with outside resources .

1. () Prenatal Care
2. () Delivery
3. () Post Part um
4. () Pregnancy Testing
5. () Nutritional Counseling
6. () Infertility Counseling

5. ACCREDITATION STATUS

Non - Accredited _____	Currently Accredited By: _____
Period of Accreditation _____	
Applying for Accreditation with _____	

6. LICENSEE IDENTIFICATION

*Name of Licensee		EIN#
Street Address	Telephone Number	FAX Number
City	State	ZIP
This entity is: (Check one)		
Public: <input type="checkbox"/> State	Not for Profit: <input type="checkbox"/> Church	For Profit: <input type="checkbox"/> Individual
<input type="checkbox"/> City	<input type="checkbox"/> Corporation	<input type="checkbox"/> Partnership
<input type="checkbox"/> Hospital District	<input type="checkbox"/> Other	<input type="checkbox"/> Corporation
*Name the principals/officers of the licensee: (such as, CEO, President, VP, Secretary, Treasurer, Director – attach additional sheet if needed)		
Name:	Address:	Phone:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

*Name of persons or entities (corporations, organizations, etc) having at least 10% interest in the licensee – attach additional sheet if needed:

Name:	Address:	Phone:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have any of these persons ever been convicted or found guilty, regardless of adjudication, in any jurisdiction, of any felony involving fraud, embezzlement, fraudulent conversion or misappropriation of property, or violence against a person or persons? Yes () No ()

If yes, attach the criminal record of the applicable individual(s) listing the court, the date of conviction, the offense and the penalty imposed for each conviction, regardless of adjudication.

Is there any injunctive or restrictive order or federal or state administrative order relating to business activity or health care as a result of an action brought by a public agency or department, including, without limitation, an action affecting a license of the administrator or other officer of the facility ?

Yes () No ()

If yes, list applicable orders:

7. EMPLOYEE INFORMATION

Name of Director of the Maternity Center

Has this person ever been convicted or found guilty, regardless of adjudication, in any jurisdiction, or any felony involving fraud, embezzlement, fraudulent conversion or misappropriation of property, violence against a person or persons, or moral turpitude? Yes () No ()

If yes, attach the criminal record of the applicable individual(s) listing the court, the date of conviction, the offense and the penalty imposed for each conviction, regardless of adjudication.
Is there any injunctive or restrictive order or federal or state administrative order relating to business activity or health care as a result of an action brought by a public agency or department, including, without limitation, an action affecting a license? Currently effective with regard to the administrator of the facility?
Yes () No ()
If yes, attach applicable

9. INTEREST IN ORGANIZATIONS PROVIDING GOODS, LEASES, OR SERVICES TO FACILITY

If applying for initial or change of licensed operator licensure, complete the following information.

List the name (A) of any person who owns at least a 10-percent interest in any professional service, firm, association, partnership, or corporation providing goods, leases, or services to the facility for which the application is made, and the name (B) and address (C) of the professional service, firm, association, partnership, or corporation in which such interest is held.

Person's Name (A)	Interest Organization (B)	Organization Address (C)

10. LIST MANDATORY INSURANCE COVERAGE

Type	Company Name	Policy Number	Policy Expiration Date

11. CERTIFICATE OF NEED

If applying for initial licensure or the addition of licensed beds, attach a copy of all pertinent Certificates of Need or a statement that the facility is exempt from review.

12. MEDICAID LIABILITY

If applying for initial or change of licensed operator licensure, attach proof of compliance with Medicaid liability requirements.

13. BUILDING CONSTRUCTION / OCCUPANCY

If applying for initial licensure for a new construction or new operation, attach the amended Certificates of approval/occupancy.
Attach current certificate of occupancy

14. LIABILITY INSURANCE

Attach proof of current liability insurance coverage on malpractice and comprehensive general coverage in accordance with Title 22 DCMR 3205 Insurance coverage. In addition, attach a proof that the insurance carrier has a certificate of authority from the Department of Insurance to operate in the District of Columbia.

15. CIVIL VERDICT OF JUDGEMENT

If applying for initial or change of licensed operator licensure, attach:

- A. Copies of any civil verdict or judgment involving the applicant within the ten years preceding the application, relating to medical negligence, violation of resident's rights, or wrongful death.
- B. Copies of any civil verdict or judgment involving the applicant, related to such matters, within 30 days after filing with the clerk of the court.

16. OUTSTANDING FINES

The agency may take action against a license or application for any facility with outstanding fines assessed by Final Order of the Health Care Regulation and Licensing Administration .

- A. Are there outstanding fines ? Yes () No ()
- B. If yes, please complete the following for each separate fine (attach additional information if necessary):
 - 1. Fine amount: \$_____
 - 2. Fines assessed by: _____ Agency for Health Care Regulation and Licensing
 _____ Others, please explain
 - 3. Survey or application date for which the fine was imposed: _____
 - 4. Due date of fine: _____
 - 5. Is there an appeal pending of a final order? Yes () No ()

17. CONTROLLING INTEREST INFORMATION

Please complete attached Form (Appendix I) with Controlling Interest information required for all persons or entities listed in sections 4 and 6.

18. BANKRUPTCY

Is the facility or its parent corporation presently operating under bankruptcy protection? Yes () No ()

19. FINANCIAL ABILITY TO OPERATE

If applying for initial or change of licensed operator licensure, provide proof of financial ability to operate, see instructions and forms required.

20. RISK MANAGEMENT AND QUALITY ASSURANCE:

If applying for initial or change of licensed operator licensure, submit the facility plan for quality assurance and for conducting risk management.

21. COMPLIANCE WITH ADMINISTRATIVE AND PROCEDURAL REQUIREMENTS

A. I agree that I will notify the Health Regulation and Licensing Administration if substantive changes in facility management and operation that significantly affect policies and procedures and that notice will be given in writing before the effective date of the change.

B. Upon licensure, the facility will follow, implement and abide by Title 22 DCMR Chapter 26 Maternity Center.

22. AFFIDAVIT

I, _____ hereby swear or affirm that the information provided in or with this application is true and correct and does comply with administrative and procedural requirements.

Subscribed and sworn to before me this _____ day of _____, 20_____.

Notary Public

Signature of Applicant

Title