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| **Documentation of Applicant’s Qualifications to Expand or Establish a Home Health Agency in Maryland**  |
| **For: Maryland Home Health Agency, Nursing Home, or Hospital Applicants** |

**Applicant:**

**If an existing home health agency, provide Maryland HHA license #:**

**1. PERFORMANCE-RELATED QUALIFICATIONS:**  COMAR 10.24.16.06.D and 10.24.16.07 outline performance-related qualifications that an applicant must meet in order to have a CON application accepted. The performance-related qualifications vary by type of applicant. MHCC staff has previously identified qualifying Maryland providers that have met the performance-related qualifications found on the Commission’s web site at: <http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/documents/chcf_con_hha_guidelines_20161114.pdf>.

To determine a potential applicant’s performance-related eligibility:

* Home Health Agencies should consult Table 1;
* Hospitals should consult Table 2; and
* Nursing homes should consult Table 3.

If potential applicant is on the qualifying list, complete question 2, provide documentation as requested, and return to MHCC.

**2. QUALIFICATIONS FOR ALL APPLICANTS:** COMAR 10.24.16.06C provides that the Maryland Health Care Commission will only docket a CON application from an applicant that meets and documents the characteristics and requirements listed immediately below. Applicants must indicate whether the statement on the left side of the grid below is true or false (or Not Applicable) and provide documentation as indicated.

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| The Applicant: |
| (1) Has not had its Medicare or Medicaid payments suspended within the last five years;  |  |
| (2) Has not been convicted of Medicare or Medicaid fraud or abuse within the last ten years;  |  |
| (3) Has received at least satisfactory findings reflecting no serious adverse citations on the most recent two survey cycles from its respective state agency, accreditation organization, or both, as applicable to the type of applicant;  | (Provide documentation of survey results.)  |
| (4) Has maintained accreditation through a state-recognized deeming authority, as applicable, for at least the three most recent years;  | (Provide documentation of accreditation.) |
| (5) Has submitted an acceptable plan of correction for any valid and serious patient-related complaint investigated over the past three years;  | (Provide documentation of accepted plan of correction.) |
| (6) Has complied with all applicable federal and State quality of care reporting requirements and performance standards;  | (Provide documentation) |
| (7) Can document availability of sufficient financial resources to implement the proposed project within the applicable timeframes set forth in the Commission’s performance requirements at COMAR 10.24.01.12; 10.24.16  | (Provide documentation\*) |
| (8) Demonstrates a record of serving all applicable payer types, such as Medicare, Medicaid, private insurance, HMOs, and self-pay patients; and | (Provide documentation of payor mix.) |
| (9) Affirms under penalties of perjury, that within the last ten years, no owner or senior management, or owner or senior management of any related or affiliated entity, has been convicted of a felony or crime or pleaded guilty, nolo contendere, entered a best interest plea of guilty, or received a diversionary disposition regarding a felony or crime. |  |
| **ATTESTATION:**I, the undersigned am an owner, or authorized agent of the applicant for the proposed home health agency service. I hereby declare and affirm under the penalties of perjury that the statements immediately preceding are true and correct to the best of my knowledge, information, and belief. Signature, Owner or Authorized Agent of the Potential Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name and Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_ |

\* Provide Audited Financial Statements for the past two years. In the absence of audited financial statements, provide documentation of the adequacy of financial resources to fund this project signed by a Certified Public Accountant who is not directly employed by the applicant.