APPLICATION FOR HOME MEDICAL EQUIPMENT PROVIDER LICENSE

Purpose

The Home Medical Equipment Provider Licensing Act of 2004 requires a license or certification of registration for facilities providing home medical equipment services to Ohio citizens. This application is to be used to obtain **a license** to provide home medical equipment services. If your facility is accredited by the Joint Commission on Accreditation of Health Organizations or another accrediting organization recognized by the Ohio Respiratory Care Board under OAC rule 4761:1-4-01 you must apply for a certificate of registration, not a license. To see a complete list of recognized accrediting organization visit www.hme.ohio.gov.

General Instructions

All Applicants, please complete the following:

- ❖ All information must be accurate and complete. Incomplete applications will not be processed and will be returned to you for completion.
- ❖ Information should be typed or printed legibly with black or blue ink.
- ❖ A separate application is required for each facility engaged in providing HME services.

The following documentation must be attached:

- ❖ A list all personnel currently employed at the HME facility, including job titles.
- ❖ A Certificate of ***Product and Professional Liability*** Insurance: showing a minimum of one million dollar per occurrence, three million dollars aggregate coverage.
- ❖ A list of persons who have criminal convictions, include title of conviction and when and where the conviction took place (This does not include traffic or moving violations)

Nonrefundable Fees

License	$300.00

Payment of all fees must be paid by check or money order made payable to: **Treasurer, State of Ohio**. All fees are nonrefundable. All returned checks for nonpayment shall be assessed a penalty of fifty dollars.

Mailing Address

Mail the completed application with the fee in the form of check or money order to:

Ohio Respiratory Care Board – HME Division
77 South High Street, 16th Floor
Columbus, Ohio 43215

Telephone No.

For assistance in completing your application or if you have any questions, please call Marcia Tatum, HME Manger at: **614-644-4732**

Internet Address

Or visit our website at: www.hme.ohio.gov

Ohio Respiratory Care Board
77 S. High Street, 16th Floor
Columbus, Ohio 43215-6108
614-752-9218
www.hme.ohio.gov

Application for HME License

General Purpose: This application is to obtain a License to provide Home Medical Equipment Services as defined under division (C) of Section 4752.01 ORC. HME equipment covered under Ohio law is listed under division (B) of Section 4752.01 ORC and rule 4761:1-3-02 OAC. Exceptions to the Ohio's HME licensing requirement are listed under division (B) of Section 4752.02 ORC. Please complete all sections and include all requested documents and application fees. Incomplete applications will be held open for ninety days; afterwards the application may be abandoned pursuant to OAC rule 4761:1-6-04.

Instructions: If a section does not apply, please mark "N/A". All incomplete applications will be returned. All fees must be submitted in the form of a check or money order made payable to the Treasurer, State of Ohio. **Pursuant to Section 4752.05 of the Ohio Revised Code, a License issued is valid from the day it is issued until the thirtieth day of June that immediately follows the date of issue. Thereafter, the License is valid only if it is renewed biennially on or before the thirtieth day of June. The issuance date of the License is the date the authorization is effective.**

PART A – Facility Information

Name of Owner or Corporation			
Name of Facility			
Facility Mailing Address, if different than above - Street	City	State	Zip
Corporation Mailing Address - Street	City	State	Zip
Phone Number of Facility	County		
Name of Authorized Representative Agent	SSN *	Date of Birth	
Facility Manager (If different than above)	SSN *	Date of Birth	
Names and Social Security Numbers of all shareholders, members or partners owning more than five percent interest (attach separate piece of paper if needed). Print or type legibly.	Names of Shareholder, members, or partners	Social Security Number	
	1.		
	2.		
	3.		
	4.		
Emergency Phone Number (must be 24 hour number)	Ohio Medicaid Number	Medicare Number	

Please give a brief description of your facility, including scope of product sold, maintained, leased or stored; facility sq. footage and any other storage facilities:

_____

_____

_____

FOR ORCB USE ONLY

Check #	Amount	Check Date/ RCO #	Receipt Date:
Executive Director's Signature	Date	License #	

* Provision of your Social Security Number is mandated for child support enforcement purposes, pursuant to Ohio Revised Code 3123.50 and 42 U.S.C. Section 1320a-7e(b), 5 U.S.C. Section 552a, and 45 C.F.R. pt. 61 for potential disclosure to the Federal Department of Health and Human Services= Healthcare Integrity and Protection Data Bank (HIPDB).

Page 2 Cont'd from Page 1. Please check all equipment that apply.

PART B – Services Provided

THE FOLLOWING ARE LISTED AS HME UNDER RULE 4761:1-3-2 OAC. PLEASE CHECK ALL THAT APPLY TO YOUR FACILITY.

"Life-sustaining equipment" means equipment prescribed by an authorized health care professional that mechanically sustains, restores, or supplants a vital bodily function, such as breathing, including but not limited to:

- ☐ Ventilators
- ☐ Oxygen Concentrators
- ☐ Oxygen Liquid Systems
- ☐ Oxygen Compressed Gas Systems
- ☐ Non Invasive Ventilator System (i.e Bi-Level, Iron Lungs, Rocking Beds, Diaphragmatic pacers, etc.)

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"Technologically-sophisticated" means medical equipment prescribed by an authorized health care professional that requires individualized adjustment or regular maintenance by an HME service provider to maintain a patient's health care condition or the effectiveness of the equipment, including but not limited to:

- ☐ Oxygen conservation devices
- ☐ CPAP (continuous positive airway pressure) devices
- ☐ Bi-level airway pressure (BiPAP) devices
- ☐ Intrapulmonary percussive ventilation (IPV) devices
- ☐ Intermittent positive pressure breathing (IPPB) devices
- ☐ Cough-assist mechanical in-exsuffaltor
- ☐ Apnea monitors
- ☐ Percussors for chest physiotherapy
- ☐ Suction machines
- ☐ Feeding pumps
- ☐ Infusion pumps
- ☐ Continuous passive motion (CPM) devices
- ☐ Transcutaneous electric nerve stimulators (TENS)
- ☐ Custom seating or positioning systems
- ☐ Custom rehab equipment (i.e. standers & gait trainers)

"Other" equipment is an item specified by the Ohio respiratory care board in rules adopted under division (b) of section 4752.17 of the revised code, including but not limited to:

- ☐ Auto-titrating airway devices
- ☐ Pulse oximeters
- ☐ Home photo therapy (Bili lights or blankets)
- ☐ Large volume air compressors for tracheostomy
- ☐ Electric wheelchairs and custom scooters
- ☐ In-home patient lifts
- ☐ Individually sized or customized accessories that are an integral part of equipment defined in paragraphs (A), (B), and (C) of this rule.

Additionally, the Board has recognized the following additional HME:

- ☐ Bone growth stimulators
- ☐ Vacuum Assisted Closure Devices (VAC)
- ☐ Drop foot stimulators

PART C - Prior Conviction Records

TO BE COMPLETED BY ALL APPLICANTS (Check not applicable box, if none to report: ☐ N/A)	
Has applicant, or any personnel therein listed, ever been convicted in a court of law, hearing, or other administrative procedure with any violation of the laws of the United States or of any individual state, relating to dangerous drugs, alcohol, fraud, theft, sexual misconduct, assault or homicide. (If "Yes", state all particulars, dates, places, and present status below)	
Name of Employee	Title of conviction (include when and where the conviction took place)
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PART D – Certification of Qualifications

TO BE COMPLETED BY ALL APPLICANTS			
To be licensed as an HME service provider, please indicate your compliance by placing your initials in the box:			
☐ Yes	☐ No	You maintain a facility to adequately store, maintain, lease or sell the home medical equipment in which they have listed on their application for licensure;	
☐ Yes	☐ No	You have trained personnel on staff to ensure that their equipment is maintained, leased and sold in a manner that is safe to the public;	
☐ Yes	☐ No	You minimally possess product and professional liability insurance coverage in the amount of one million dollars per occurrence, three million dollars aggregate;	
☐ Yes	☐ No	You have a filing system established to document all sales and leases of medical equipment, including pertinent medical records;	
☐ Yes	☐ No	You meet all established federal, state and local rules and regulations regarding the maintenance, storage and sale of home medical equipment.	

PART E - Other licenses (Check not applicable box, if none apply: ☐ N/A)

FDA# _____	DOT# _____	Pharmacy Lic. # _____

PART F – Practice Questions (Please initial Yes/No answers)

1. **How long has this HME facility been renting, selling, delivering, installing, maintaining, replacing or demonstrating the HME services (as defined under OAC rule 4761:1-3-02) to Ohio citizens? Since _____ (mo/yr)**

2. **Have you ever been denied a license, certification, or registration as an HME facility in any state, for any reason?**
   ____ Yes ____ No

3. **Has any license or accreditation associated with the practice of HME ever been revoked, suspended, or conditionally approved?**
   ____ Yes ____ No

4. **Have you ever violated any provision of the Ohio Revised Code, including providing HME services to Ohio citizens without a license or registration?**
   ____ Yes ____ No

TO BE COMPLETED BY ALL APPLICANTS

I do solemnly swear or affirm that the answers appearing heron are true and correct to the best of my knowledge and belief, that I am legally authorized to sign for this business, and that this business complies with all applicable federal and State licensure and regulatory requirements; maintains a physical facility and medical equipment inventory (there shall only be one license permitted at each address); establishes proof of commercial general liability insurance, including but not limited to, coverage for products liability and professional liability; establishes and provides records of annual continuing education for personnel engaged in the delivery, maintenance, repair, cleaning and inventory control, and financial management of home medical equipment and services; maintains personnel policies, if applicable; makes life sustaining home medical equipment and services available 24 hours per day and 7 days a week; and complies with any additional qualifications for licensure as determined by rule of the board.

_____	_____	_____
Type or print name of authorized representative agent **(Person officially authorized to sign for facility)**	Signature of authorized representative agent	Date