

# APPLICATION FOR HOME MEDICAL EQUIPMENT PROVIDER CERTIFICATE OF REGISTRATION

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## 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 **certificate of registration** to provide home medical equipment services. Only facilities accredited by the Joint Commission on Accreditation of Health Organizations or other accrediting organizations recognized by the Ohio Respiratory Care Board under OAC rule 4761:1-4-01 may apply for a certificate of registration. To see a complete list of recognized accrediting organization visit [www.hme.ohio.gov](http://www.hme.ohio.gov).

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## General Instructions

- ❖ 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 complete Certification and Accreditation form (*see last page of application*), **completed by the accrediting organization**
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## Nonrefundable Fee

Certificate of registration

\$150.00

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

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

## Mailing Address

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

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## Telephone No.

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

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## Internet Address

Visit our website at: [www.hme.ohio.gov](http://www.hme.ohio.gov)

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Ohio Respiratory Care Board  
 77 S. High Street, 16<sup>th</sup> Floor  
 Columbus, Ohio 43215-6108  
 614-752-9218

[www.hme.ohio.gov](http://www.hme.ohio.gov)

# Application for HME Certification

**General Purpose:** This application is to obtain a Certification of Registration 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 4752.12 of the Ohio Revised Code, a Certificate of Registration issued is valid from the day it is issued until the thirtieth day of June that immediately follows the date of issue. Thereafter, the Certificate of Registration is valid only if it is renewed biennially on or before the thirtieth day of June. The issuance date of the Certificate of Registration is the date the authorization is effective.**

- PART A – Facility Information**
- Please check if this is a facility relocation. Current License or Registration # (HMER. \_\_\_\_\_) or (HMEL. \_\_\_\_\_)
- Please check if this is a change from a license to a registration. Current lic.# (HMEL. \_\_\_\_\_)

Name of Owner or Corporation		
Corporation Mailing Address - Street	City	State Zip
Name of Facility		
Facility Mailing Address, if different than above - Street	City	State Zip
Phone Number of Facility	County	
Name of Authorized Representative Agent	SSN * Last four digits _____	Date of Birth
Facility Manager (If different than above)	SSN * Last four digits _____	Date of Birth
Names and last four digits of 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.	Last four digits _____
	2.	Last four digits _____
	3.	Last four digits _____
Emergency Phone Number (must be 24 hour number)	Ohio Medicaid Number	Medicare Number
	4.	Last four digits _____
Name of Accrediting Body	Accreditation # (if applicable)	Accreditation Expiration Date
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	Certificate of Registration #	

\* 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).

**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.)

**"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-exsufflator
- 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
- Vision Restoration Therapy Devices

**PART C – Other licensure (Check not applicable box, if none apply:  N/A)**

FDA# _____	DOT# _____	Pharmacy Lic. # _____
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**PART D – 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 certificate of registration or 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

## CERTIFICATION OF ACCREDITATION

**CERTIFICATE OF REGISTRATION APPLICANT:** Complete the applicant section of this form, and then forward this form to your accrediting organization. This form should be returned to you, not the Board, for inclusion in your application filing. Do not file your application until your accrediting organization has completed this form. You are authorized to photocopy this form as necessary.

LEGAL NAME OF BUSINESS

ASSUMED NAME OF BUSINESS OR DBA NAME

ADDRESS: STREET, CITY, STATE, ZIP CODE

TELEPHONE NUMBER (Include Area Code)  
Area Code ( \_ \_ \_ ) \_ \_ - - - - -

I hereby authorize \_\_\_\_\_ to furnish to the Ohio Respiratory Care Board, the information requested below:

\_\_\_\_\_  
Type or print name of owner or person designated to sign for firm

\_\_\_\_\_  
Signature of owner or person designated to sign for firm

\_\_\_\_\_  
Type or print title of owner or person designated to sign for firm

\_\_\_\_\_  
Date

**ACCREDITING AGENCY: RETURN COMPLETED FORM TO APPLICANT**  
Please record N/A in areas, which are not applicable.

ACCREDITATION NUMBER	ACCREDITATION STATUS	DATE ACCREDITATION ISSUED	DATE ACCREDITATION EXPIRES

Have any inspections of the applicant produced a deficiency rating resulting in a conditional or removal of accreditation? (If yes, please explain)  Yes  No

SIGNATURE	TITLE	DATE

NAME AND ADDRESS OF ACCREDITING ASSOCIATION:

**PLEASE RETURN FORM TO FACILITY FOR INCLUSION WITH CERTIFICATE OF REGISTRATION PACKET**