

# 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 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 organizations 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 of 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 Fees (Read Carefully!)

Pursuant to OAC 4761:1-8-01, if the Certificate of Registration application is filed on or after January 1<sup>st</sup> of an even year, but before June 30<sup>th</sup> of the same year, the Board will waive the initial Certificate of Registration fee, but require the renewal fee for the following biennial licensing cycle.

For applications filed (date stamped by the RCB office) **on or after January 1<sup>st</sup> of an even year, but before June 30<sup>th</sup> of the same year**, the Initial Certificate of Registration Fee is waived. Instead, a Renewal Fee of **\$300.00** is required.

**On all other filing dates**, the initial fee is: **\$150.00**

Payment of all fees must be paid by **check/money order** made payable to: **Treasurer, State of Ohio**. All fees are nonrefundable.

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## Mailing Address

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

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 L. Tatum, HME Manager, at: **614-644-4732**

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## Internet Address

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

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## 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 ORC Section 4752.01. HME equipment covered under Ohio law is listed under division (B) of ORC Section 4752.01 and OAC rule 4761:1-3-02. Exceptions to the Ohio's HME licensing requirement are listed under division (B) of ORC Section 4752.02. 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/money order made payable to the Treasurer, State of Ohio. Pursuant to ORC Section 4752.12 (B), a Certificate of Registration is valid from the day it is issued until the thirtieth day of June of the even year that immediately follows the date of issue, unless the certificate of registration is issued within six months of this date. Any certificate of registration issued less than six months prior to June thirtieth of an even year, will have the initial application fee waived, but must pay the renewal fee for the following biennial period. Thereafter, the certificate of registration is valid only if it is renewed biennially on or before the thirtieth day of June of an even year. 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	
		1.	
		2.	
		3.	
Emergency Phone Number (must be 24 hour number)		Ohio Medicaid Number	Medicare Number
Email Address		Federal Tax I.D. *	
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 #	

\* Your Federal Tax I.D. number is required by federal law for purposes of reporting to the Federal Healthcare Integrity and Protection Data Bank (42 U.S.C. Sections 1320a-7e(b), 5 U.S.C. Section 552a, and 45 C.F.R. pt. 61). It may also be used for reporting to law enforcement authorities for investigative/law enforcement purposes in compliance with ORC 4761.031, and/or as otherwise required by state and federal law.

**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:**

- |  |   |
|--|---|
| <input type="checkbox"/> Ventilators           | <input type="checkbox"/> Oxygen Compressed Gas Systems  |
| <input type="checkbox"/> Oxygen Concentrators  | <input type="checkbox"/> Non Invasive Ventilator System (i.e. Bi-Level, Iron Lungs, Rocking Beds, Diaphragmatic pacers, etc.) |
| <input type="checkbox"/> Oxygen Liquid Systems |   |

**"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:**

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

**"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:**

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|--|--|
| <input type="checkbox"/> Auto-titrating airway devices                 | <input type="checkbox"/> Electric wheelchairs and custom scooters  |
| <input type="checkbox"/> Pulse oximeters                               | <input type="checkbox"/> In-home patient lifts   |
| <input type="checkbox"/> Home phototherapy (Bili lights or blankets)   | <input type="checkbox"/> Individually sized or customized accessories that are an integral part of equipment defined in paragraphs (A), (B), or (C) of OAC rule 4761:1-3-02. |
| <input type="checkbox"/> Large volume air compressors for tracheostomy |  |

**Additionally, the Board has recognized the following additional HME:**

- |  |   |
|--|---|
| <input type="checkbox"/> Bone growth stimulators               | <input type="checkbox"/> Drop foot stimulators              |
| <input type="checkbox"/> Vacuum Assisted Wound Closure Devices | <input type="checkbox"/> 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!)**

- 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)**
- Have you ever been denied a license, certification, or registration as an HME facility in any state, for any reason?**  
 \_\_\_ Yes \_\_\_ No
- Has any license or accreditation associated with the practice of HME ever been revoked, suspended, or conditionally approved?**  
 \_\_\_ Yes \_\_\_ No
- 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 hereon 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.

I hereby request that in order to process my application, act upon renewal requests, and to respond to public requests to confirm my license/certificate status, my personal information be accessed in accordance with OAC 4761:1-16-05(D)(2)(d)(ii).

\_\_\_\_\_  
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. Your accrediting organization must send this form directly to the Board, for inclusion in your application filing. You are authorized to photocopy this form as needed.

## APPLICANT SECTION

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: \_\_\_\_\_ (Accrediting Organization)

\_\_\_\_\_  
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 SECTION

**RETURN COMPLETED FORM TO THE BOARD**  
Please record N/A in areas, which are not applicable.

ACCREDITATION NUMBER	ACCREDITATION STATUS	DATE ACCREDITATION ISSUED	DATE ACCREDITATION EXPIRES
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Have any inspections of the applicant produced a deficiency rating resulting in less than full accreditation status or removal of accreditation? (If yes, please explain)

Yes

No

NAME OF PERSON COMPLETING FORM – TYPE OR PRINT LEGIBLY

SIGNATURE

TITLE

DATE

NAME AND ADDRESS OF ACCREDITING ASSOCIATION:

**PLEASE RETURN FORM TO THE**

**OHIO RESPIRATORY CARE BOARD**  
77 S. HIGH STREET, 16<sup>TH</sup> FL.  
COLUMBUS, OH 43215