APPLICATION FOR HOME MEDICAL EQUIPMENT PROVIDER CERTIFICATE OF REGISTRATION

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.

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.**

Nonrefundable Fees (Read Carefully!)

Pursuant to OAC 4761:1-8-01, if the Certificate of Registration application is filed on or after January 1st of an even year, but before June 30th 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 1st of an even year, but before June 30th 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.

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, 16th Floor
Columbus, Ohio 43215

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**

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 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 (See Page 2 for specifically defined HME). 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: 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.		
	4.		
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.**

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.)

"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
- ☐ Continuous positive airway pressure devices (CPAP)
- ☐ Bi-level positive airway pressure devices (BiPAP)
- ☐ Intrapulmonary percussive ventilation devices (IPV)
- ☐ Intermittent positive pressure breathing devices (IPPB)
- ☐ Cough-assist mechanical in-ExSufflator
- ☐ Apnea monitors
- ☐ Percussors for chest physiotherapy
- ☐ Suction machines
- ☐ Feeding pumps
- ☐ Infusion pumps
- ☐ Continuous passive motion devices (CPM)
- ☐ Custom seating or positioning systems
- ☐ Custom rehab equipment (i.e. standers & gait trainers)
- ☐ Vacuum Assisted Wound Closure Devices
- ☐ Drop foot stimulators
- ☐ Bone growth stimulators
- ☐ Vision Restoration Therapy Devices
- ☐ Electric wheelchairs and custom scooters
- ☐ Auto-titrating airway devices
- ☐ In-home patient lifts

"Other items" means equipment specified by the board under division (B) (3) of section 4752.01 of the Revised Code and division (B) of section 4752.17 of the Revised Code. Other items include, but are not limited to:

- ☐ Pulse oximeters
- ☐ Home phototherapy (Bili lights or blankets)
- ☐ 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.
- ☐ Transcutaneous electronic nerve stimulators (TENS), excluding devices labeled by the federal food and drug administration for over-the-counter use and are identified with the federal food and drug administration product code "NUH.OTC TENS".

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

FDA# _____	DOT# _____	Pharmacy Lic. # _____

PART D – Practice Questions (Please Initial (not check) 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 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 by direct mail or scanned email, 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

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, 16TH FL.
COLUMBUS, OH 43215
Or
email scanned color copy to:
HMEmanager@rcb.state.oh.us