

**ALABAMA BOARD OF HOME MEDICAL
EQUIPMENT SERVICES PROVIDERS**

Post Office Box 240636

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Web-Site: www.homemed.alabama.gov

INSTRUCTIONS FOR STATE LICENSURE APPLICATION

IMPORTANT INFORMATION: YOU MAY BE OUT OF COMPLIANCE WITH MEDICARE REQUIREMENTS. The Alabama Board of Home Medical Equipment Services Providers was created by Act #2000-419. Effective August 1, 2000, the Board is authorized to provide for the licensure and regulation of Home Medical Equipment Services Providers; to prohibit the un-licensed practice of providing home medical equipment services; and to provide penalties for violations. Specifically, pursuant to the Home Medical Equipment Services Providers Act, "An entity or person found providing home medical equipment services without a license as required by this act shall be subject to an administrative fine of one thousand dollars (\$1,000) per day that services were provided without a license." Also, Medicare, Medicaid, Blue Cross & Blue Shield could be notified of same and your provider number suspended.

Accreditation by the Joint Commission on Accreditation of Healthcare Organizations, the Community Health Accreditation Program, or other accrediting entities shall not be substituted for the compliance with this act.

General Statement: The Board desires to provide courteous and timely service to all applicants. To maximize its efficiency and the level of service, the Board will process complete applications only. Incomplete applications will be returned to you. Read all instructions carefully. The Board will not act as your agent in gathering information or supporting documents necessary for the consideration of your application. Make all checks payable to the Alabama Board of Home Medical Equipment Services Providers and send to P.O. Box 240636; Montgomery, AL 36124-0636.

Application Instructions: Applications must be typewritten or printed in ink and must be legible. Complete the entire application. **Leave no space blank.** If a particular question or request for information does not apply to you, put a short line of N/A in the blank space or cross out the entire section to indicate the question(s) or section has received your attention. Failure to supply necessary information may result in denial of the application. If the answer to any of the attached questions is "Yes", you must enclose with this application complete information with respect to all circumstances and the final result, if such has been reached. A "Yes" answer does not necessarily mean the applicant will not be granted a license. However, additional documentation may be requested by the Board if the information submitted is insufficient.

NOTE: A license is required for each physical location and not per business. Location on this application must be discibility accessible.

**APPLICATION FOR HOME MEDICAL EQUIPMENT
SERVICES PROVIDER LICENSE**

Type of Application (please check one): **New** **Change of Address**
 Other Change (PIC, FEIN #, etc.)

Applicant Information

Legal Business Name: _____
(D.B.A., Trade, or Business Name)

Street Address: _____

City, State, Zip Code: _____

Phone: (____) _____ FAX: (____) _____

E-mail Address: _____

Preferred Mailing Address (for mailing purposes only):

City, State, Zip Code: _____

FEIN# or SS#: _____ Date Business Started: __/__/____

Yes No Are patient records stored at this location?

If "No", where are they kept? _____

Business License Information

Issued By (City): _____ License Number: _____

Effective Date: __/__/____ Renewal Date: __/__/____

**ATTACH A COPY OF EACH REQUIRED FEDERAL, STATE, AND/OR LOCAL
AUTHORITY COUNTY/CITY BUSINESS LICENSE OR REGISTRATION. IF NO
LOCAL LICENSE REQUIRED, YOU MUST ATTACH A LETTER FROM THE
OFFICIAL OFFICE STATING SAME.**

Type of Business

Sole Proprietor Partnership Joint Venture

Business Corporation Limited Liability Corporation

Other: _____

Equipment Categories

General HME (canes, crutches, walkers, commodes, etc.)

Oxygen & Respiratory

Hospital Beds & Accessories

Wheelchair, Mobility Equipment & Accessories

Stair Lifts or Platform Lifts

Other: _____

Do you deliver, install, and maintain the equipment and/or instruct the consumer on the proper use of the equipment once delivered?

Yes No

How do you deliver the equipment to the consumers home? _____

Business Hours

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Open							
Close							

Does the Company Signage reflect these hours? Yes No

Do you provide after hours coverage/on-call? Yes No

Phone number for that coverage: (____) _____

Liability Insurance

APPLICANT MUST ATTACH A COPY OF THEIR LIABILITY INSURANCE POLICY TO THIS APPLICATION REFLECTING THE SAME PHYSICAL LOCATION ON THIS APPLICATION.

Insurance Company Name: _____

Policy Number: _____ Date Issued: ____/____/____

Expiration Date: ____/____/____ Agent Name: _____

Agent Phone #: (____) _____ Agent FAX #: (____) _____

Professional Licenses (i.e.: Registered Nurse, Pharmacist, etc.)

IMPORTANT NOTE: This section must be completed by the person in charge.

Type License	License # & State	Expiration Date

Have any licenses ever been denied, conditioned, curtailed, limited, restricted, suspended, or revoked in any way? Yes No

If "Yes", explain. (Use additional sheets for complete detailed explanation if needed):

Applicant Information (Applicant means an individual applicant in the case of sole proprietorship, or any officer, director, agent, managing employee, general manager, or person in charge, or any partner or shareholder having an ownership interest in the corporation, partnership, or other business entity. For each entity/person with any ownership interest in applicant, copy this page and complete in its entirety for each individual.

Legal Business Name: _____

D/b/a/ name: _____

Your Name: _____ Title: _____

Home Address: _____

City, State, Zip Code: _____

Home Phone #: (____) _____ SSN: _____

Date of Birth: ____/____/____ Birth State: ____ Birth County: _____

Parent/Home Office Information (If applicable)

Name: _____

CEO: _____

Address: _____

City, State, Zip Code: _____

Phone #: _____ FAX #: _____

E-Mail: _____ FEIN#: _____

- Your Affiliation:
- | | |
|--|---------------------------------------|
| <input type="checkbox"/> Joint Venture/Partnership | <input type="checkbox"/> Wholly Owned |
| <input type="checkbox"/> Managed | <input type="checkbox"/> Subsidiary |
| <input type="checkbox"/> Operated | <input type="checkbox"/> Leased |
| <input type="checkbox"/> Other: _____ | |

Check if this entity/owner has EVER had any of the following adverse actions imposed by the Medicare, Medicaid, or any other federal agency program. For each box checked, include the date the adverse legal action was imposed. Check all that apply or the "none of these" box. Attach copies of adverse legal action notification.

- | | |
|---|---|
| <input type="checkbox"/> Administrative Sanctions(s) ____/____/____ | <input type="checkbox"/> Criminal Fines ____/____/____ |
| <input type="checkbox"/> Program Exclusion(s) ____/____/____ | <input type="checkbox"/> Restitution Order(s) ____/____/____ |
| <input type="checkbox"/> Suspension of Payment(s) ____/____/____ | <input type="checkbox"/> Pending Civil Judgments(s) ____/____/____ |
| <input type="checkbox"/> Civil Monetary Penalty(s) ____/____/____ | <input type="checkbox"/> Pending Criminal Judgments(s) ____/____/____ |
| <input type="checkbox"/> Assessment(s) ____/____/____ | <input type="checkbox"/> Judgments(s) Pending False |
| <input type="checkbox"/> None of These | Claims Act ____/____/____ |

Does this entity/owner have any outstanding criminal fines? Yes No

Does this entity/owner have any outstanding restitution orders? Yes No

Has this entity/owner ever been convicted of any health care related crimes?

Yes No

Has this entity/owner ever been convicted of a felony under Federal or State law?

Yes No

Statement to the Board (This section must also be copied and completed for each individual involved in this company)

Administrative Code of Alabama CHAPTER 473-X-1-(1) Applicant means an individual applicant in the case of a sole proprietorship, or any officer, director, agent, managing employee, general manager, or person in charge, or any partner or shareholder having an ownership interest in the corporation, partnership, or other business entity.

I, _____ being first duly sworn declare under penalty of perjury as follows:

I am the applicant described and identified in this application for licensure in the State of Alabama.

To the best of my knowledge, the information contained in this application and its supporting document(s) is truthful, correct, and complete; and discloses all material facts regarding the applicant and associated individuals necessary to properly evaluate the applicant's qualifications for licensure.

I will ensure that any information subsequently submitted to the Board in conjunction with this application or its supporting documents meets the same standards as set forth above.

I understand that it is unlawful and punishable as a Class A misdemeanor to apply for or obtain a license or otherwise deal with the Board through the use of fraud, forgery, or intentional deception, misrepresentation, misstatement, or omission.

I understand that this application will be classified as a public record and will be available for the inspection by the public, except with regard to the release of information which is classified as controller, private, or protected under the Government Records Access and Management Act or restricted by other law.

Has the applicant ever been convicted of any health related crime?

Yes No

Has the applicant ever been convicted of a felony under Federal or State Law?

Yes No

Has any family or household member of the applicant ever been convicted, assessed, or excluded from the Medicare or Medicaid program due to fraud, obstruction or an investigation, filing of false claims, or providing false information? Yes No

I, _____ being duly sworn, depose and say I certify that I have read, understand, meet, and will continue to meet all supplier standards outlined in 42CFRG424.57 and comply with the Rules and Regulations of the Alabama Board of Home Medical Equipment Services Providers and have truthfully and completely disclosed all ownership and control of the applicant, and that all information submitted on/or with this application is true and complete. I hereby authorize all persons, institutions, organizations, schools, governmental agencies, employers, references, or any others not specifically included in the preceding characterization, which are set forth directly or by reference in this application, to release to the Board, records or information required for the Board to properly evaluate my qualifications for licensure by the State of Alabama.

Signature of Applicant

Date of Signature

Subscribed and Sworn to before me this _____ day of _____, 20_____.

Signature of Notary Public

Printed Name of Notary Public

My Commission Expires

(SEAL)

**BEFORE SUBMITTING YOUR APPLICATION, PLEASE REVIEW
THE CHECKLIST TO ENSURE THAT ALL REQUIRED
DOCUMENTS HAVE BEEN SUBMITTED.**

- All sections of the application are complete and sections that do not pertain to your location are indicated so with “N/A” or “X”;
- Inspection fee in the amount of \$500.00 for New Location or \$275 for Change of Address made payable to the Alabama Board of Home Medical Equipment Services Providers;
- Copy of City or County Business License;
- Copy of State of Alabama Business License (which is purchased from your county courthouse) or State of Alabama Revenue Sales Tax License (Out of State Suppliers are exempt from this requirement);
- Copy of Certification of Insurance (The policy must reflect the limits of coverage, \$300,000 being the minimum requirement and reflect the physical location on the application);
- Copy of State of Alabama Board of Pharmacy Oxygen Permit if supplying oxygen (Out of State Suppliers are exempt from this requirement);
- Copy of Elevator Contractors License issued by the State Elevator Board under the Department of Labor if supplying stair lifts and platform lifts;
- All individuals affiliated with the ownership of the company have completed the Person in Charge information and is properly notarized.

Note: Please be advised that all supporting documents required must reflect the physical address of that stated on the first page of this application.

General Application Processing Information:

Important Note: Please allow adequate time when applying for licensure prior to opening facility. The Alabama Board of Home Medical Equipment Services Providers is committed to providing timely service and expeditious application processing. Due to the application and site inspection requirements, please allow approximately two to four weeks for the completion of the licensure process. The following are the steps involved in acquiring a license for the typical applicant:

- Complete Application – Applications are reviewed and processed in order of receipt. If an application is incomplete for any reason, the applicant is written regarding the deficiencies and given ninety (90) days to complete. If the application is not completed ninety (90) days from the date of the notification of deficiencies, the application will expire and a new application will be required.
- Pass Site Inspection – Once the application is complete the Board Inspector is notified to schedule a site inspection. The inspector will contact the applicant and schedule a date and time for inspection. Site Inspections are also done in order of receipt. The inspection will consist of reviewing all applicable licenses for the facility as listed in the application and compliance with the Supplier Standards which can be found at www.homemed.alabama.gov
- Notification of Site Inspection Results – The inspector will send the completed site inspection form to the Board office. The Board will notify the applicant of the site inspection results. If the site inspection is passed, the licensure fee of \$250.00 will then be required. If the site inspection is failed, the applicant will be written of the specific deficiencies, options for appeal, and guidelines to re-inspection.
- Certificate Mailed – The Licensure Certificate will be mailed to the applicant's business address as listed on the application upon completion of the above steps. Certificates will not be overnighted or faxed to applicants. Again, please allow adequate time for the completion of the licensure process. All certificates expire on August 31st regardless of date of issue due to statutory limitations. Upon renewal applicants will have a full annual license.

Return completed application to:

**The Alabama Board of Home Medical Equipment Services Providers
P.O. Box 240636
Montgomery, AL 36124-0636**

Make checks payable to:

**The Alabama Board of Home Medical Equipment Services Providers or
ABHMESP**