ALABAMA BOARD OF HOME MEDICAL EQUIPMENT
P.O. Box 240636
Montgomery, AL 36124-0636
Phone: 334-215-3474
FAX: 334-215-3457
Web Site: www.homemed.alabama.gov

APPLICATION FOR OUT OF STATE DESIGNATION (OUT OF STATE BRANCH OR LOCATION PROVIDING SERVICES ON BEHALF OF THE LICENSED LOCATION)

Note: This application is to be submitted by a currently Licensed Home Medical Equipment Provider in the State of Alabama who wishes to designate an out of state location. Specifically, this designation is only for out of state locations applying to operate under an instate licensed location as provided for in the below Rule:

473-X-3-02 – A provider of home medical equipment that has a principal place of business outside this state and has established a licensed, instate location may provide home medical equipment and services to its Alabama customers through any corporate branch or location, including an out of state location that is not otherwise eligible for an exemption from licensure pursuant to ALA. Code § 34-14C-5, as permitted under the CMS DMEPOS Supplier Standards and applicable regulations. For purposes of this rule, a corporate branch or location does not include a corporate subsidiary or affiliate that would itself require a license from this Board; the branch or location should be a provider of home medical equipment services that is duly licensed in accordance with applicable law in the state in which it is located. The ownership of the provider's licensed instate location, as defined in Rule 473-X-3-.01(7) (h), will be responsible to the Board for any equipment or services provided to the customer by any other corporate branch or location.

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 and mail 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 or "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.

Section 1 - Licensed Location Information

Legal Business Name: _____

Alabama Home Medical Equipment License Number: _____

Effective Date: ___/____/____ Renewal Date:____/____/_____

Physical Location: _____

_____

_____

Phone: _____ FAX: _____

E-mail: _____

Web Site: _____

Person in Charge: _____

FEIN# or SSN: _____

Section 2 - Out of State Location 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 SSN: _____ Date Business Started: __/__/____

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: _____

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):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Section 3 - 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: _____

☐ check this box if this individual is to be designated as the Person in Charge on the license

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:
- ☐ Joint Venture/Partnership
- ☐ Managed
- ☐ Operated
- ☐ Other: _____
- ☐ Wholly Owned
- ☐ Subsidiary
- ☐ Leased

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.

- ☐ **Administrative Sanctions(s) ___/___/_____**
- ☐ **Program Exclusion(s) ___/___/_____**
- ☐ **Suspension of Payment(s) ___/___/_____**
- ☐ **Civil Monetary Penalty(s) ___/___/_____**
- ☐ **Assessment(s) ___/___/_____**
- ☐ **None of These**
- ☐ **Criminal Fines ___/___/_____**
- ☐ **Restitution Order(s) ___/___/_____**
- ☐ **Pending Civil Judgments(s) ___/___/_____**
- ☐ **Pending CriminalJudgments(s)___/___/___**
- ☐ **Judgments(s) Pending False 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

Are you a citizen of the United States? ☐ Yes ☐ No

Are you a Military Spouse? □ Yes □ No

Section 4 - 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 designation 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 designation.

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 designation 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 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 understand that my current in-state Alabama Home Medical Equipment License is responsible to the Board for any equipment or services provided to the customer by any other corporate branch or location. I understand that my-out-of state designation is required to meet all supplier standards outlined in 42CFRG424.57 and comply with the Rules and Regulations. I understand that my out-of-state designation must be renewed annually with the renewal of my in-state licensed location.

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 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

(SEAL)

_____
My Commission Expires