Alabama Board of Home Medical Equipment
60 Commerce Street Suite 1440 Montgomery, AL 36104
Phone: 334-215-3474 FAX: 334.801-9579
***Email*: chaustin3@gmail.com**
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 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; 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 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 2777 Zelda Road, Montgomery, AL 36106.

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 disability accessible.

APPLICATION FOR HOME MEDICAL EQUIPMENT LICENSE

Type of Application (please check one): □ New
□ Business Name Change (EIN Change)

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: _____

☐ 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 □ Wholly Owned
□ Managed □ Subsidiary
□ Operated □ Leased
□ 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.

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

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

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 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

_____ (SEAL)
My Commission Expires

Alabama Board of Home Medical Equipment Services Providers
Proof of Citizenship (POC) Form – for Initial HME License

Instructions:

- This form is to be completed by applicants for licensure in order to comply with Ala. Code § 31-13-7 (1975 as amended).
- This form must be completed by each individual affiliated with the ownership of the company and by the applicant (if other than an owner of the company). Copies of this form may be made as needed.
- Please mail this completed form with a **copy** of the required documentation proving citizenship or legal presence to: The Alabama Board of Home Medical Equipment Services Providers, 2777 Zelda Road, Montgomery, AL 36106. **Do not send originals or faxes of citizenship/legal presence documents.**

Name (Please Print): _____ Permit #: _____

Track I: Please complete this section if you are a United States Citizen. Check all that apply below:

- o I am a United States Citizen. I am submitting the attached COPY of my document to prove citizenship/legal presence:
  Please check and submit one of the following:
- o Alabama Driver's License or Identification issued by the Department of Public Safety
- o Driver's License from other state that required proof of lawful presence
- o Birth Certificate indicating U.S. Birth
- o Valid U.S. Passport
- o Military Identification showing U.S. place of Birth
- o Naturalization documents
- o Certificate of Citizenship
- o Consular report of birth abroad of U.S. Citizen
- o Bureau of Indian Affairs Identification
- o American Indian Card issued by Homeland Security
- o Final adoption decree showing person's name and place of U.S. Birth
- o A valid Uniformed Services Privileges and Identification Card
- o Extract from a United States hospital record of birth created at the time of the person's birth indicating the place of birth in the United States
- o Certification of Birth Issued by U.S. Department of State

I hereby declare that I am a citizen of the United States of America. I sign this declaration under penalty of perjury; making a false or fictitious statement or representation in this declaration is perjury in the second degree, pursuant to Ala. Code § 13A-10-102.

_____ _____

Signature Date

Track II: Please complete this section of you are not a United States Citizen. Check all that apply below:

- o I am not a United States Citizen. I am submitting the attached COPY of my document to prove legal presence:
  Please check and submit one of the following:
- o I-327 Re-entry Permit
- o I-551 Permanent Resident Card
- o I-571 Refugee Travel Document
- o I-766 Employment Authorization Card
- o I-94 Arrival/Departure Record
- o Unexpired Foreign Passport
- o Temporary I-551 Stamp (on passport or I-94)
- o I-20 Certificate of Eligibility for non-immigrant (F-1) student status
- o DS 2019 Certificate of Eligibility for Exchange Visitor (J-1) status
- o Machine-readable immigrant Visa (with temporary I-551 language)
- o Other: Explain: _____

I hereby declare that I am an alien lawfully present in the United States of America. I sign this declaration under penalty of perjury; making a false or fictitious statement or representation in this declaration is perjury in the second degree, pursuant to Ala. Code § 13A-10-102.

Signature Date

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 and Licensure fee of $250.00, made payable to the Alabama Board of Home Medical Equipment.
- ❑ Copy of City or County Business License;
- ❑ Copy of State of Alabama Business License (which is purchased from your county courthouse)
- ❑ Copy of Certification of liability Insurance accord form (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.
- ❑ 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.
- ❑ All individuals affiliated with the ownership of the company and Person In Charge have to send in Proof of Citizenship and HME POC Form.

Note: Please be advised that all supporting documents required must reflect the <u>physical address</u> 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 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 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
60 Commerce Street Suite 1440
Montgomery, AL 36104

Make checks payable to:
The Alabama Board of Home Medical Equipment or ABHME