

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

- | | | |
|---|--|--|
| <input type="checkbox"/> Sole Proprietor | <input type="checkbox"/> Partnership | <input type="checkbox"/> Joint Venture |
| <input type="checkbox"/> Business Corporation | <input type="checkbox"/> Limited Liability Corporation | |
| <input type="checkbox"/> Other: _____ | | |

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 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
 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

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

My Commission Expires

(SEAL)

BEFORE SUBMITTING YOUR APPLICATION, PLEASE REVIEW THE BELOW 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”.
- All individuals affiliated with the ownership of the company have completed the Section 3 – Applicant Information.
- All individuals affiliated with the ownership of the company have completed Section 4 – Statement to the Board and is properly notarized.
- If the answer to any of the disclosure questions is “yes”, information is attached with respect to all circumstances and the final result, if such has been reached.
- Enclosed a check or money order made payable to the Alabama Board of Home Medical Equipment (or ABHME) in the amount of \$1,000.00 (Processing Fee for Out of State Branch or Location Providing Services on Behalf of a Licensed Location).

Return complete application to:
The Alabama Board of Home Medical Equipment
P.O. Box 240636
Montgomery, AL 36124-0636

Make check or money order payable to:
The Alabama Board of Home Medical Equipment or ABHME

**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, P.O. Box 240636, Montgomery, AL 36124-0636. **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:

- 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:
- Alabama Driver's License or Identification issued by the Department of Public Safety
- Driver's License from other state that required proof of lawful presence
- Birth Certificate indicating U.S. Birth
- Valid U.S. Passport
- Military Identification showing U.S. place of Birth
- Naturalization documents
- Certificate of Citizenship
- Consular report of birth abroad of U.S. Citizen
- Bureau of Indian Affairs Identification
- American Indian Card issued by Homeland Security
- Final adoption decree showing person's name and place of U.S. Birth
- A valid Uniformed Services Privileges and Identification Card
- 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
- 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 if you are not a United States Citizen. Check all that apply below:

- 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:
- I-327 Re-entry Permit
- I-551 Permanent Resident Card
- I-571 Refugee Travel Document
- I-766 Employment Authorization Card
- I-94 Arrival/Departure Record
- Unexpired Foreign Passport
- Temporary I-551 Stamp (on passport or I-94)
- I-20 Certificate of Eligibility for non-immigrant (F-1) student status
- DS 2019 Certificate of Eligibility for Exchange Visitor (J-1) status
- Machine-readable immigrant Visa (with temporary I-551 language)
- 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