STATE OF MAINE
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF LICENSING AND CERTIFICATION
-

Medical Facilities Unit – Acute Care

End Stage Renal Disease Facility

SECTION 1: Facility Information			
Facility Name:			
Doing Business As:			
Mailing Address:			
City:	State:	Zip:	County:
Physical Address:			
City:	State:	Zip:	County:
Telephone No.: ( )		Fax No.: ( )	
Email Address:			

SECTION 2: Fees - all fees are non-refundable	
APPLICATION FOR END STAGE RENAL DISEASE FACILITY	
☐ New Application (fee $450)	$ _____
☐ Renewal Application (fee $450) License Renewal Period (dates): _____ to _____	$ _____
Make checks or money orders payable to "Treasurer, State of Maine". Do not send Cash. Credit Cards are not accepted at this time. **Total Checks/Money Orders enclosed =**	**$ _____**

For questions regarding this program and/or application, please contact the following:
Department of Health and Human Services
Licensing and Certification
Medical Facilities – Acute Care Program
41 Anthony Ave; 11 State House Station
Augusta, ME 04333-0011

Tel: (207) 287-9300 Fax: (207) 287-9252 Toll Free: 1-800-791-4080 TTY users call Maine relay 711
Email: DLRS.MedFacilities@maine.gov

Office Use Only:
Check# _____ *MO #* _____ *Amount $*_____ *Initials:* _____ *License#* _____

SECTION 3: Ownership Information (Use additional sheets, if necessary)

Type of Entity:

☐ For Profit ☐ Not-for-Profit ☐ Public

Not-for-Profit. Additional Information.

List the name and address of the President of the Board of Directors or the appropriate Municipal Government Representative.

Name Address

_____ _____

_____ _____

SECTION 4: Facility Information (Use additional sheets, if necessary)

Name of Person in Charge:			Title:
Home Address:			
City:	State:	Zip:	County:
Home Telephone No.: ( )		Office Telephone No.: ( )	

Facility Location:

Is this Unit/Facility Hospital-Based? ☐ No ☐ Yes, Name of Hospital: _____

Is this Unit/Facility SNF-Based? ☐ No ☐ Yes, Name of SNF: _____

Multi-Facility Organization:

Is this facility owned and/or managed by a multi-facility organization? ☐ No ☐ Yes, please complete the following:

Geographic area served: _____

Name of Parent Organization Address Telephone Number

_____ _____

_____ _____

Services Provided: Please select all that apply.

☐ Hemodialysis
☐ Peritoneal Dialysis
☐ Home Training – Hemodialysis
☐ Home Training – Peritoneal Dialysis
☐ Home Support - Hemodialysis
☐ Home Support – Peritoneal Dialysis
☐ Other: _____

Is reuse practiced? ☐ No ☐ Yes, check all that apply: ☐ Manual ☐ Semi-Automated ☐ Automated

Number of Dialysis Patients: _____ Total Patients = _____ Hemodialysis Patients + _____ Peritoneal Dialysis Patients

Number of Stations: TOTAL #_____

Hemodialysis #_____ Home Training #_____ Isolation Stations #_____

Generators:

Does this facility have a generator: ☐ No ☐ Yes, number of kilowatts: _____

Staffing: Select all that apply. Indicate the number of Full-Time equivalents. (Use decimals when necessary, i.e. 3.5)

☐ Registered Nurse	_____	☐ Licensed Practical Nurse	_____
☐ Social Worker	_____	☐ Dietitian	_____
☐ Technician	_____	☐ Other: _____	_____

Name of Medical Director:

SECTION 5: Submission

Submit your completed application with the following:

- A check or money order made payable to "Treasurer, State of Maine"
- A copy of any and all leases, if the building(s) used is leased.
- Letter(s) from the appropriate Municipal Official(s) that demonstrates compliance with all Local Ordinances relative to zoning and building code regulations. Applicable for Initial applicants or if you have moved since your last renewal.

SECTION 6: Declaration

The applicant certifies that all information contained in this application is true and correct to the best of his/her knowledge.

The Department of Health and Human Services reserves the right to request/review any additional information that will be necessary to determine the suitability of the applicant for licensure.

I, _____, being duly authorized to assume responsibility for the conduct of the agency herein described, do hereby apply for a license to operate the agency and do agree to assume responsibility that the facility will comply with all current regulations of the Department of Health and Human Services, as authorized by Title 22, MRSA Chapter 1681, Sections 8621-8631.

_____	_____	_____
Print name of Administrator	**Signature of Administrator**	**Date**