KENTUCKY BOARD OF DURABLE MEDICAL EQUIPMENT SUPPLIERS
APPLICATION FOR HOME MEDICAL EQUIPMENT LICENSE OR RENEWAL

If necessary, attach additional pages to fully answer each question. A license expires on September 30 two (2) years following its date of issuance.

1. License type: ☐ New license ☐ Renewal ☐ Reciprocal license or renewal

2. Business name that shall appear on the license:_____

3. Address of premises to appear on license: _____

_____

State:_____Zip:_____

(The license must be displayed at this address)

4. Tax ID Number:_____

5. Business type: ☐ Sole Proprietor or Partnership ☐ Corporation or LLC

6. Phone number for licensed premises:_____

7. Email address:_____

8. Business hours for licensed premises:

S: _____M:_____T: _____W: _____Th: _____F: _____S: _____

9. If applicable, emergency phone number provided to consumers:_____

If the business is a partnership, please provide the information requested in Questions 9, 10, 11, and 12 for all partners. If the business is a Corporation or LLC, please provide the information requested in Questions 9, 10, 11, and 12 for all officers.

10. Name:_____ Title:_____

11. Mailing address:_____

12. Phone number:_____ 13. Primary email address:_____

If you answer "Yes" to Questions 14 through 19, provide the jurisdiction, date, circumstances, and disposition and penalty for each conviction, Alford plea, or plea of nolo contendere.

14. Have you or any owner of the business ever been convicted of or entered an Alford plea or plea of nolo contendere to a sex crime as defined in KRS 17.500? ☐ No ☐ Yes

15. Have you or any owner of the business ever been convicted of or entered an Alford plea or plea of nolo contendere to a criminal offense against a victim who is a minor as defined in KRS 17.500? ☐ No ☐ Yes

16. Have you or any owner of the business ever been convicted of or entered an Alford plea or plea of nolo contendere to a felony offense under KRS Chapter 209? ☐ No ☐ Yes

17. Have you or any owner of the business ever been convicted of or entered an Alford plea or plea of nolo contendere to an offense which would classify you as a violent offender under KRS 439.3401? ☐ No ☐ Yes

18. Have you or any owner of the business ever been convicted of or entered an Alford plea or plea of nolo contendere to any felony charge? ☐ No ☐ Yes

19. Have you or any owner of the business ever violated the home medical equipment laws, rules, or administrative regulations of this state, any other state, or the federal government? ☐ No ☐ Yes

20. Below, please check the appropriate boxes depending on whether you are applying for an Initial License, Renewal License, or a Reciprocal License. If you are renewing a reciprocal license, please choose "Reciprocal License or Renewal."

☐ **A. INITIAL LICENSE.** In support of my application for a license, I agree to pay the $350 license fee. I further swear or affirm that:
☐ I am accredited or exempted by _____, a national accreditation organization approved by the Centers for Medicare & Medicaid Services that accredit suppliers of durable medical equipment. A copy of that accreditation is attached; or
☐ I can comply with the requirements of KRS Chapter 309.400 through 309.422 and 201 KAR Chapter 47 and request an inspection be performed of the premises listed above within 60 days of this application.
NOTE: ☐ If this initial application is required due to a change of address, please provide your previous license number issued by the Board:_____.

☐ **B. RENEWAL LICENSE.** In support of my application for a license renewal, I agree to pay the $350 renewal fee. I further swear or affirm that:
☐ I am accredited or exempted by _____, a national accreditation organization approved by the Centers for Medicare & Medicaid Services that accredit suppliers of durable medical equipment. A copy of that accreditation is attached; or
☐ I can comply with the requirements of KRS Chapter 309.400 through 309.422 and 201 KAR Chapter 47 and request an inspection be performed of the premises listed above within 60 days of this application.

☐ **C. RECIPROCAL LICENSE OR RENEWAL.** In support of my application for a reciprocal license, I agree to pay the $350 reciprocal license fee or reciprocal license renewal fee. I further swear or affirm that:
☐ I am licensed to provide home medical equipment and services in the state(s) of _____. I have attached a certified copy of my license.
☐ No other state of licensure has issued or taken any disciplinary or regulatory licensing action. If my any state of licensure has issued or taken any disciplinary or regulatory licensing action, I have provided a copy of my disciplinary or licensing history and attached an explanation.

21. CERTIFICATION BY APPLICANT. I certify that the information provided in this application is true and accurate and that I have read and understand the provisions of KRS Chapter 309.400 through 309.422 and 201 KAR Chapter 47 and that the licensee will comply with those provisions. I understand and agree that I will notify the Kentucky Board of Durable Medical Equipment if there is any change in the information provided in this application.

I also give the Board my consent to conduct a criminal history background check and to provide the information necessary for the Board to conduct a criminal history background check.

_____

SIGNATURE **TITLE** **DATE**