KENTUCKY BOARD OF DURABLE MEDICAL EQUIPMENT SUPPLIERS

P. O. Box 1360
Frankfort, Kentucky 40602
Phone (502) 892-4251
http://kbdmes.ky.gov/

[~~KENTUCKY BOARD OF DURABLE MEDICAL EQUIPMENT SUPPLIERS~~]
APPLICATION FOR LICENSURE[~~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)

Telephone number:_____

Email address:_____

4. Home Office Physical Location: _____

(If different from above)

_____

State:_____ Zip:_____

Telephone number:_____

Email address: _____

5. Home Office Mailing Address: _____

(If different from above)

_____

State: _____ Zip: _____

Telephone number: _____

Email address: _____

6. Physical Location in Kentucky: _____

(If different from above)

_____

State: _____ Zip: _____

Telephone number: _____

7. Kentucky Mailing Address: _____

(If different from above)

_____

State: _____ Zip: _____

Telephone number: _____

(list any additional locations on separate sheet)

8[4].Tax ID Number: _____

9[~~5~~].Business type: □ Sole Proprietor or Partnership □ Corporation or LLC

[~~6.Ph~~one number for licensed premises: _____]

[~~7.Email address: _____~~]

10[~~8~~].Business hours for licensed premises:

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

11[~~9~~]. ~~[If applicable, emergency phone]~~ Telephone number provided to customers[~~consumers~~]:_

If the business is a partnership, please provide the information requested in Questions 12-15[~~9, 10, 11, and 12~~] for all partners. If the business is a Corporation or LLC, please provide the information requested in Questions 12-15[~~9, 10, 11, and 12~~] for all officers.

12[~~10~~].Name:_____Title:_____

13[~~11~~].Home Mailing address:_____

14[~~12~~].Personal telephone[~~Phone~~] number:_____

15[~~13~~]. Personal[~~Primary~~] email address:_____

If you answer "Yes" to Questions 16-21[~~14 through 19~~], provide the jurisdiction, date, circumstances, and disposition and penalty for each conviction, Alford plea, or plea of nolo contendere.

16[~~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

17[~~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

18[~~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

19[~~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

20[~~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

21[~~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. I understand that there is an inspection fee in accordance with 201 KAR 47:010 Section 9.

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. I understand that there is an inspection fee in accordance with 201 KAR 47:010 Section 9.

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 contiguous state(s) of _____. I have attached a certified copy of my license.

☐ This state offers reciprocity to Kentucky under _____ statute.

☐ 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.

☐ 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. I understand that there is an inspection fee in accordance with 201 KAR 47:010 Section 9.

[~~21.~~]**CERTIFICATION BY APPLICANT.** I certify under penalty of perjury that the information contained herein is true, correct, and complete to the best of my knowledge and belief. I am aware that, should an investigation at any time disclose any such misrepresentation or falsification, my application could be rejected or my license revoked by the Kentucky Board of Durable Medical Equipment Suppliers.**[**~~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 Suppliers 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**