



Office of Health Facilities

Application for Maternity Center Facility

Reference Guide for New Applicants

Let's begin!

Log In to the platform

1 Enter your username and password.

2 Click the Log In button.



TIP: If you don't have an account click the **Create New Account** link.

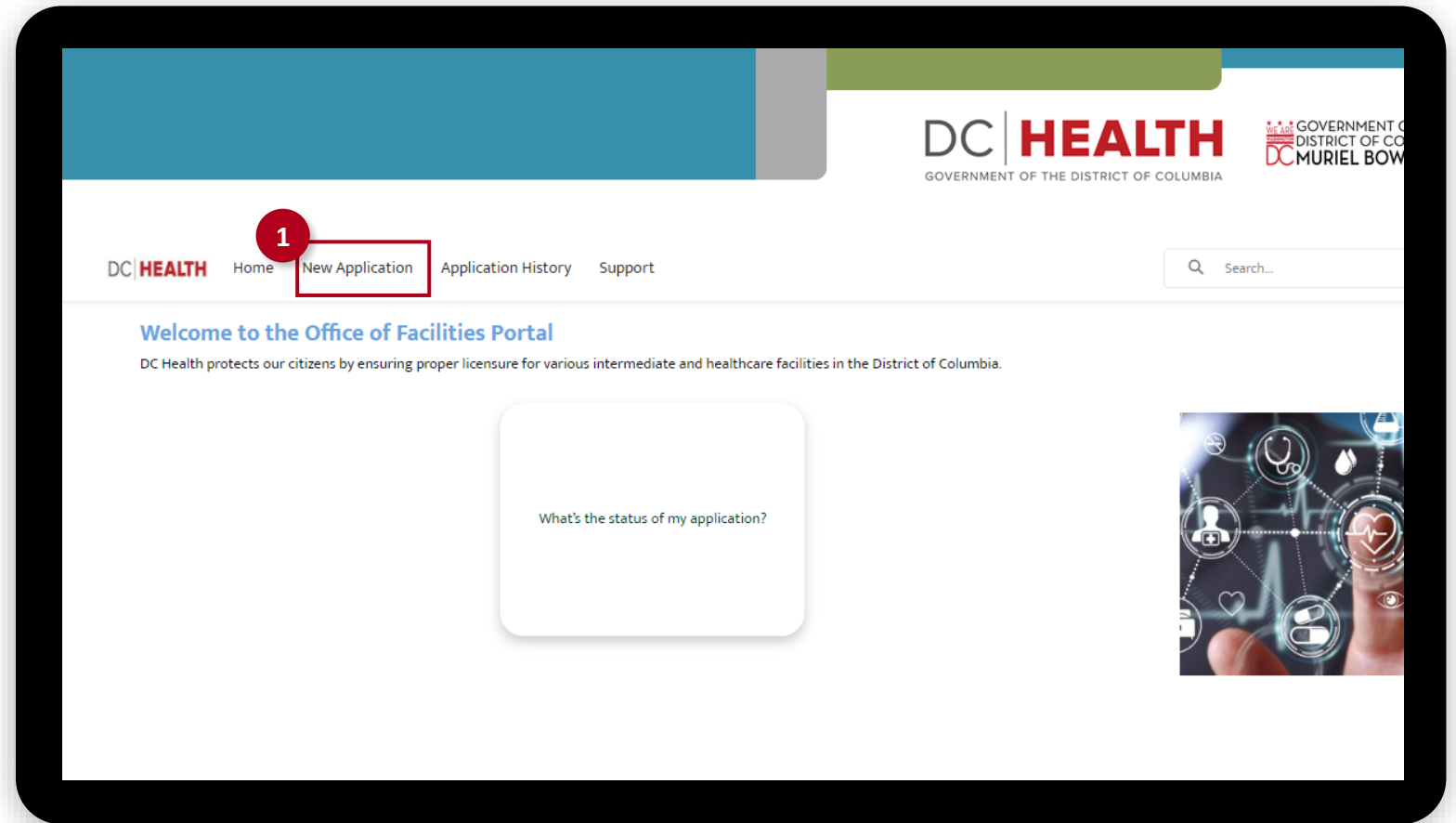
The screenshot shows the DC Health login page. At the top right, there is a header with the DC Health logo and the text "GOVERNMENT OF THE DISTRICT OF COLUMBIA" and "MURIEL BOWSER, MAYOR". The main content area features the DC Health logo, a "Welcome to the Office of Health Facilities Portal" message, and a "Login or Create an Account to:" section with a list of actions: "Apply for a new medical facility license", "Renew an existing medical facility license", "Check the status of past applications", and "Seek support related to interactions with this office". Below this is an "About DC Health" section. The login form consists of a username field (containing "TestUser17"), a password field (containing "....."), and a "Log in" button. A red box highlights the username and password fields, with a "1" in a red circle next to it. Another red box highlights the "Log in" button, with a "2" in a red circle next to it. Below the login form are links for "Forgot your password?", "Forgot username?", and "Create New Account".



Navigate to the New Application screen

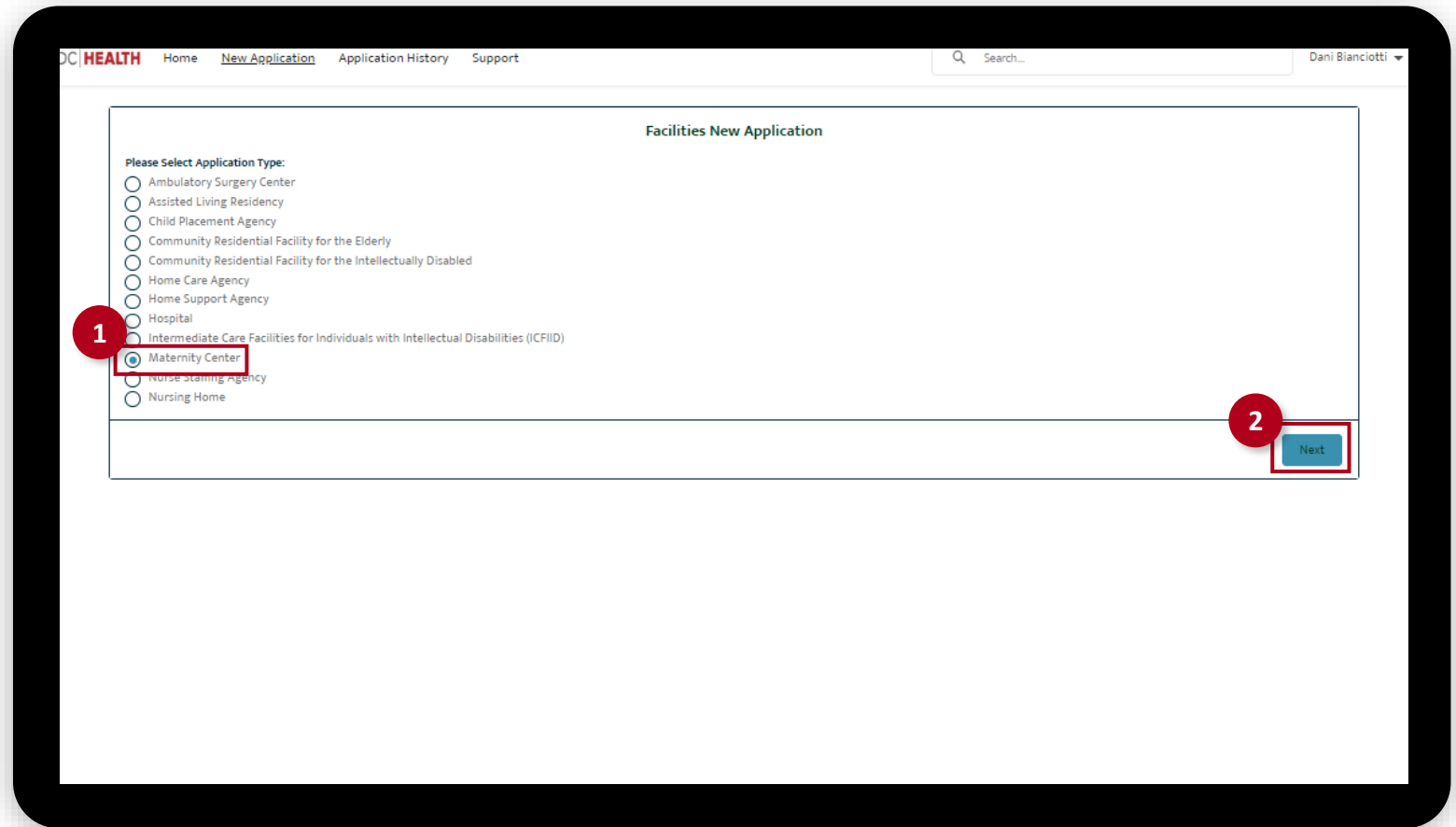
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Once you Log in to the Office of Facilities Portal, click the **New Application** tab.



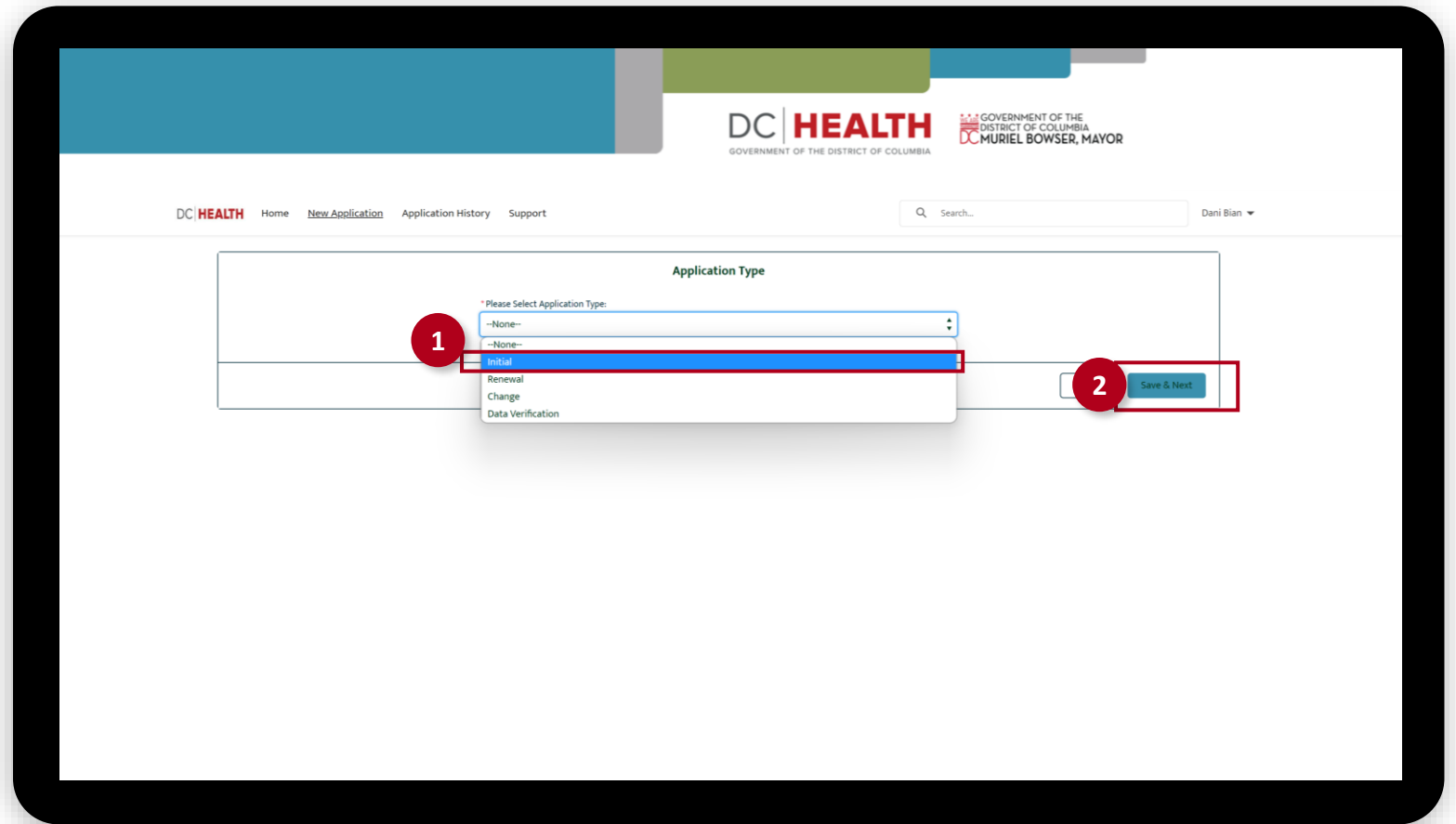
Select the Facilities New Application

- 1 Select the **Maternity Center** option from the list.
- 2 Click the **Next** button.



Select the Application Type

- 1 Select the **Initial** option from the drop-down list.
- 2 Click the **Save & Next** button.



Fill out the Facility Information

- 1 Fill out all the required fields.
- 2 Click the **Save and Next** button.

The screenshot shows a web form for facility information. A red border highlights the form area. A red circle with the number '1' is at the top left, pointing to the form fields. A red circle with the number '2' is at the bottom right, pointing to the 'Save & Next' button.

Fields in the form include:

- * Zip Code: 19974
- * Telephone Number: 607-280-6389
- * Fax Number: 670-732-0340
- * Email Address: your.email+fakedata42666@gmail.com
- * Facility Owned or Leased?: Owned
- * Number of Birth Rooms: 20
- * Fiscal Year: 2022
- * Deliveries in Previous Fiscal Year: 20
- * Is the facility or its parent corporation presently operating under bankruptcy protection?: No
- * Types of Services Provided:
 - Prenatal Care (Direct)
 - Prenatal Care (Contracted)
 - Delivery (Direct)
 - Delivery (Contracted)
 - Post Part Um (Direct)
 - Post Part Um (Contracted)
 - Pregnancy Testing (Direct)
 - Pregnancy Testing (Contracted)
 - Nutritional Counseling (Direct)
 - Nutritional Counseling (Contracted)
 - Infertility Counseling (Direct)
 - Infertility Counseling (Contracted)
- * Accredited?: No
- Applying for Accreditation with: [Empty field]

Buttons: Upload Files, Or drop files, Save & Next.

The fields marked with * are mandatory and must be filled out to continue.



TIP: Use the **Upload Files** button to attach needed documentation for the **Facility Owned or Leased** field.

Fill out the Licensee Identification Information

- 1 Fill out all the required fields.
- 2 Click the **Save and Next** button.

Public: State

Please provide documentation for principals/officers of the management company (CEO, President, VP, Secretary, Treasurer, Director) to include name, address, telephone number and email address.

Upload Files Or drop files

Please provide documentation for persons or entities (corporations, organizations, etc) having at least 10% interest in the licensee to include name, address, telephone number and email address.

Upload Files Or drop files

* Has this person ever been convicted or found guilty, regardless of adjudication, in any jurisdiction, of any felony involving fraud, embezzlement, fraudulent conversion or misappropriation of property, or violence against a person or persons?

No

If yes, attach the criminal record of the applicable individual(s) listing the court, the date of conviction, the offense and the penalty imposed for each conviction, regardless of adjudication.

Upload Files Or drop files

* Is there any injunctive or restrictive order or federal or state administrative order relating to business activity or health care as a result of an action brought by a public agency or department, including, without limitation, an action affecting a license of the administrator or other officer of the facility?

No

If yes, attach applicable.

Upload Files Or drop files

Save & Next

The fields marked with * are mandatory and must be filled out to continue.



TIP: If needed, use the **Upload Files** button to attach relevant documentation.

Fill out the Employee Information

- 1 Fill out all the required fields.
- 2 Click the **Save and Next** button.

The screenshot shows a web form with the following fields and instructions:

- 1** (Red callout) points to the top section: "If yes, attach the criminal record of the applicable individual(s) listing the court, the date of conviction, the offense and the penalty imposed for each conviction, regardless of adjudication." Below this is an "Upload Files" button and "Or drop files" text.
- A dropdown menu with "No" selected, preceded by an asterisk: "* Is there any injunctive or restrictive order or federal or state administrative order relating to business activity or health care as a result of an action brought by a public agency or department, including, without limitation, an action affecting a license? Currently effective with regard to the administrator of the facility?"
- Below the dropdown: "If yes, attach applicable." followed by another "Upload Files" button and "Or drop files" text.
- Form fields for: "Name of Center's Financial Officer" (Maxime voluptas atque reprehenderit), "Name of Director of Nurse Midwifery Services" (Nicole Bayer), "Name of the Director of Medical Affairs" (Juanita Parker), "District of Columbia Advance Practice License No" (586), and "DC Physician License Number" (613).
- Section: "Enter the number of persons employed by the Facility according to profession." with input fields for:
 - *Registered Nurses: 2
 - *Nurse Midwives: 3
 - *Licensed Social Workers: 2
 - *Physicians: 4
 - *Other: 4
- 2** (Red callout) points to the "Save & Next" button at the bottom right.



TIP: If needed, use the **Upload Files** button to attach relevant documentation.

The fields marked with * are mandatory and must be filled out to continue.

Fill out the Management Company Information

- 1 Fill out all the required fields.
- 2 Click the **Save and Next** button.

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Management Company Information

* Is the facility managed by an entity other than the licensee?

No

Please provide documentation for principals/officers of the management company (CEO, President, VP, Secretary, Treasurer, Director) to include name, address, telephone number and email address.

Upload Files Or drop files

Please provide documentation for persons or entities (corporations, organizations, etc) having at least 10% interest in the management company to include name, address, telephone number and email address.

Upload Files Or drop files

Save & Next

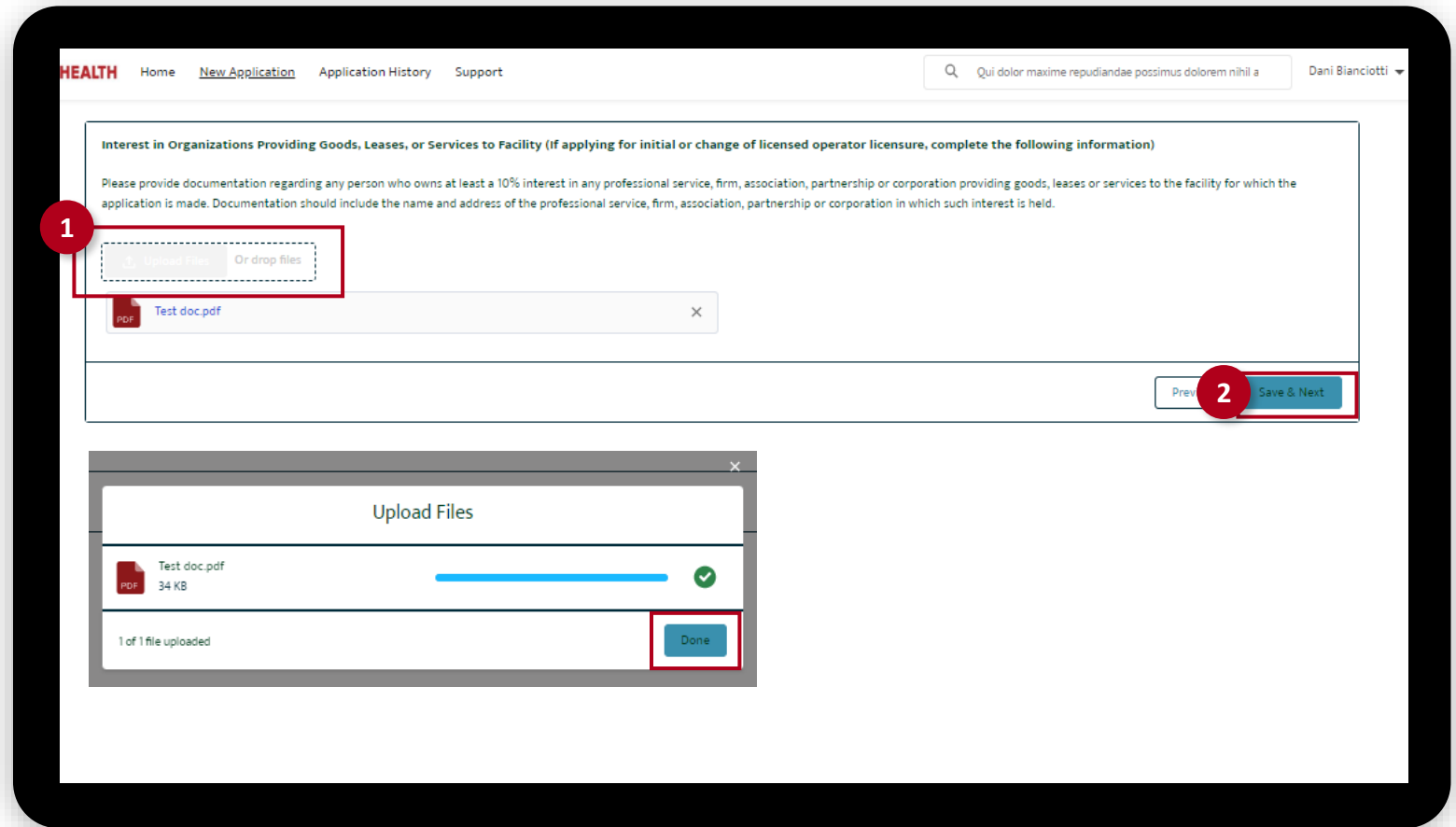


TIP: If needed, use the **Upload Files** button to attach relevant documentation.

The fields marked with * are mandatory and must be filled out to continue.

Upload Documentation

- 1 Click the **Upload Files** button to upload needed documentation regarding any person who owns at least 10% interest in any professional service, firm association, partnership or corporation providing goods, leases or services to the facility. Once the document is selected and the checkmark appears, click the **Done** button in the pop-up.
- 2 Click the **Save & Next** button.



The fields marked with * are mandatory and must be filled out to continue.

Complete the Miscellaneous Information

- 1 Fill out all the required fields.
- 2 Click the **Save and Next** button.

certificate of authority from the Department of Insurance to operate in the District of Columbia.

Or drop files

If applying for initial or change of licensed operator licensure, attach:
A. Copies of any civil verdict or judgment involving the applicant within the ten years preceding the application, relating to medical negligence, violation of resident's rights, or wrongful death.
B. Copies of any civil verdict or judgment involving the applicant, related to such matters, within 30 days after filing with the clerk of the court.

Or drop files


The agency may take action against a license or application for any facility with outstanding fines assessed by Final Order of the Health Care Regulation and Licensing Administration or of the Centers for Medicare and Medicaid Services.

* Are there outstanding fines?
No

If yes, please complete the following for each separate fine (attach additional information if necessary):

Or drop files

Fine Amount:	<input type="text"/>	Fines Assessed By:	--None--
Survey or application date the fine was imposed:	<input type="text"/>	Due date of fine:	<input type="text"/>
Is there an appeal pending of a final order?	--None--		

 **TIP:** If needed, use the **Upload Files** button to attach relevant documentation.

The fields marked with * are mandatory and must be filled out to continue.

Complete the Miscellaneous Information

- 3 Fill out all the required fields.
- 4 Click the **Save and Next** button.

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Miscellaneous - Cont'd

Is the facility or its parent corporation presently operating under bankruptcy protection?
No


If applying for initial or change of licensed operator licensure, provide proof of financial ability to operate, see instructions and forms required.

Upload Files Or drop files

If applying for initial or change of licensed operator licensure, submit the facility plan for quality assurance and for conducting risk management.

Upload Files Or drop files

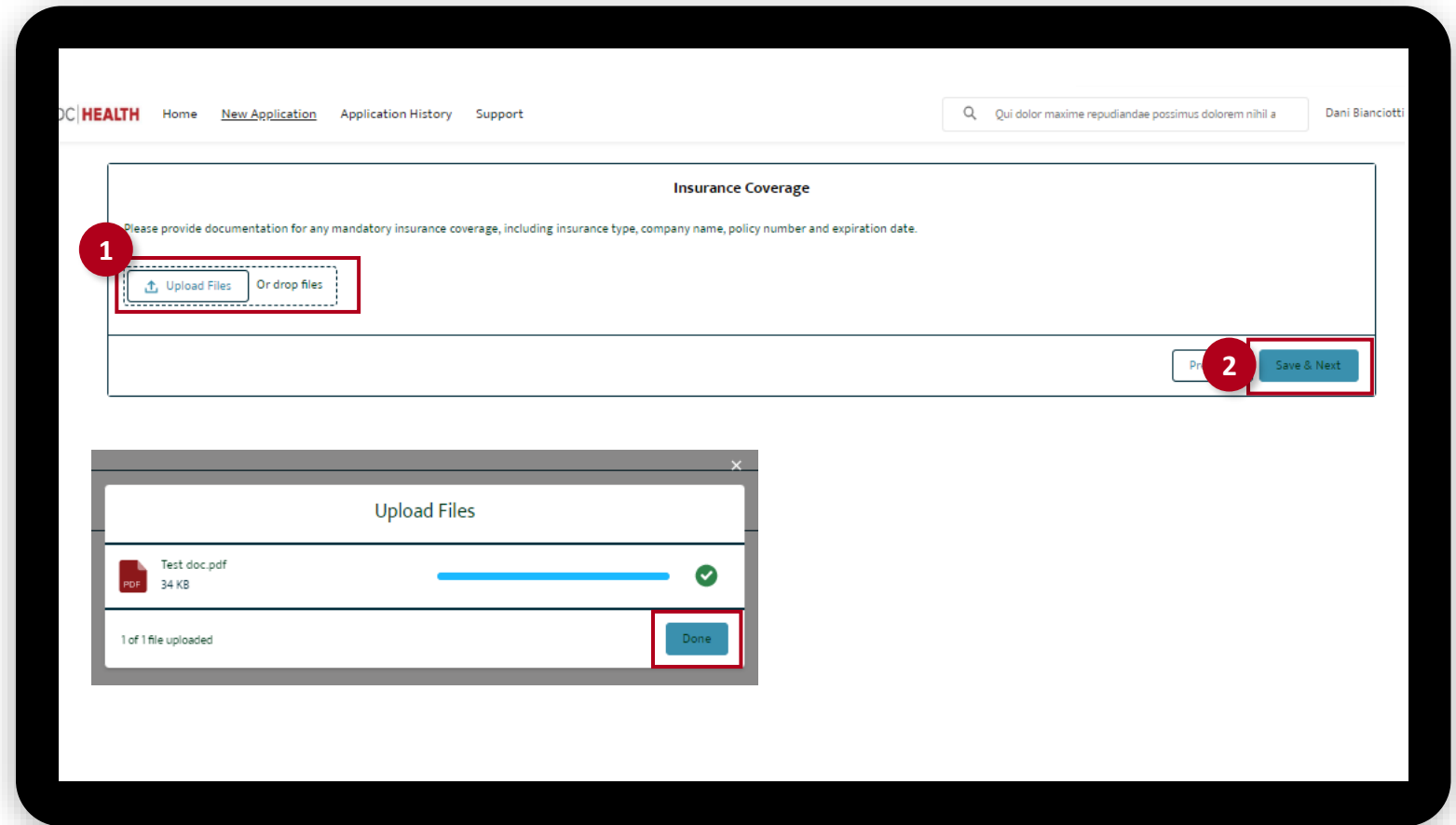
Save & Next

 **TIP:** If needed, use the **Upload Files** button to attach relevant documentation.

The fields marked with * are mandatory and must be filled out to continue.

Upload the Insurance Coverage Documents

- 1 Click the **Upload Files** button to upload documentation for Insurance Coverage. Once the document is selected and the checkmark appears, click the **Done** button in the pop-up.
- 2 Click the **Save & Next** button.



The fields marked with * are mandatory and must be filled out to continue.

Payment Wizard



1 Fill out the **Billing Address** and **Payment Info** fields.

2 Click the **Pay** button.

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Payment Wizard

Please complete the payment for your application using the form below. Click "Pay" when you are done inputting your payment details. If you are unable to pay at this time, you may exit this saved draft and return to it in the "Application History" tab of the portal header later.

After your payment has processed, click "Next" below to certify and submit the application. Your application will not be reviewed until these steps have been completed.

1

Billing Address	Payment Info
7429 Shanahan Via	Elza Abbott
953 Hadley Lakes	3714 496353 98431
North Jaylon	11 / 25
New Mexico ?
32284	

2 Pay \$390.00

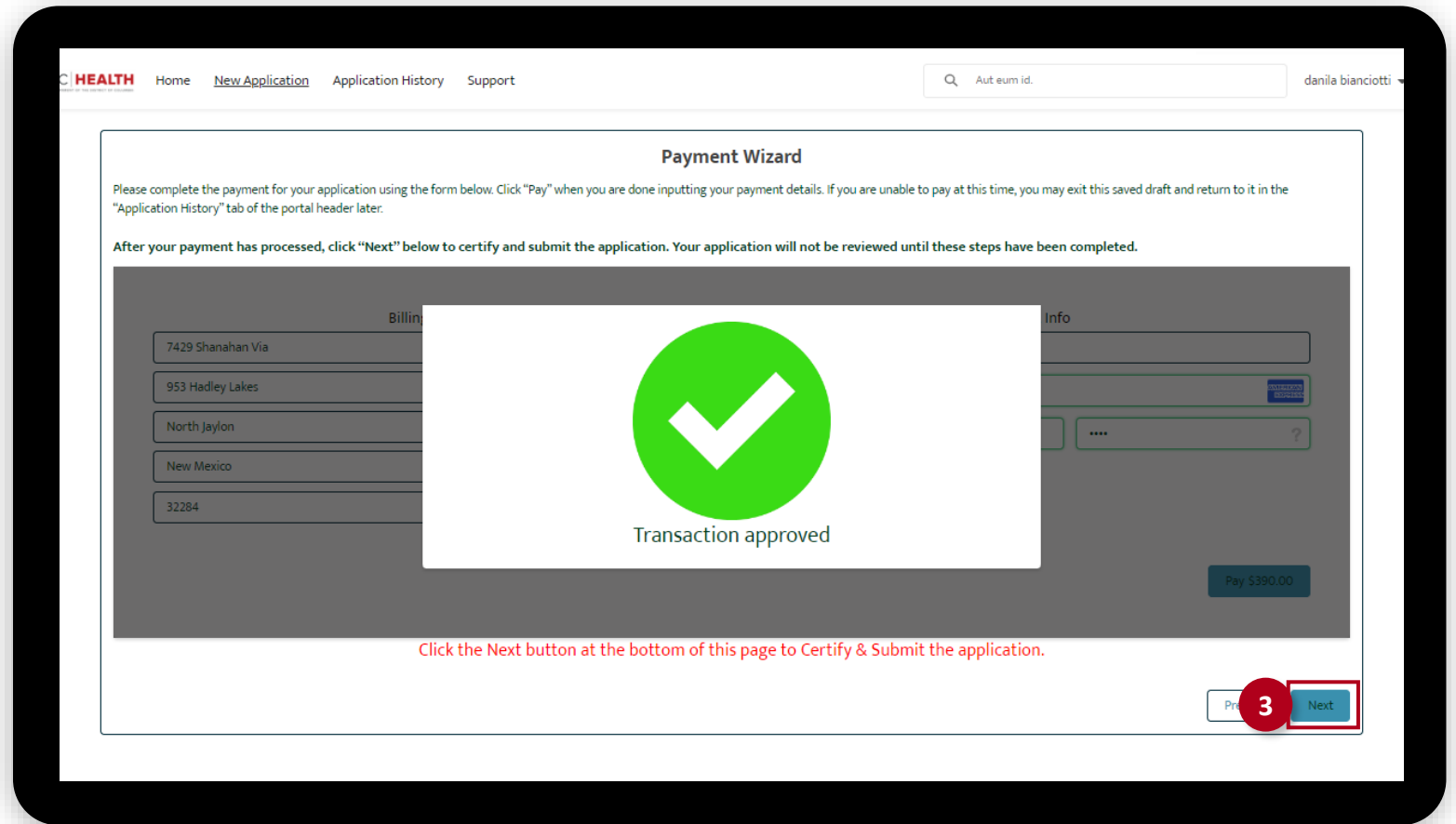
Click the Next button at the bottom of this page to Certify & Submit the application.

Previous Next

Payment Wizard



- 3 Once the Transaction is approved, click the **Next** button.



Certify and Submit

1 Fill out the Name and Date fields.

2 Click the Save & Next button.

GOVERNMENT OF THE DISTRICT OF COLUMBIA

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Certify and Submit

By clicking the submit button below, you are acknowledging that you are providing information for an official record and that the information you are supplying is true. By submitting this information, you understand that knowingly and willfully making a false statement on an official record may result in action against your license, registration, or certification and criminal penalties*. This information will be held confidential by the Department of Health.

(a) A person commits the offense of making false statements if that person willfully makes a false statement that is in fact material, in writing, directly or indirectly, to any instrumentality of the District of Columbia government, under circumstances in which the statement could reasonably be expected to be relied upon as true; provided, that the writing indicates that the making of a false statement is punishable by criminal penalties or if that person makes an affirmation by signing a declaration under § 1-1061.13, knowing that the facts stated in the filing are not true in any material respect or if that person makes an affirmation by signing a declaration under § 1-1061.13, knowing that the facts stated in the filing are not true in any material respect;

(b) Any person convicted of making false statements shall be fined not more than the amount set forth in § 22-3571.01 or imprisoned for not more than 180 days, or both. A violation of this section shall be prosecuted by the Attorney General for the District of Columbia or one of the Attorney General's assistants.

By electronically entering my name on this form, I attest that all statements are true and accurate.

* Name
Frankie Lynch

Date
January 24, 2023

Save & Next

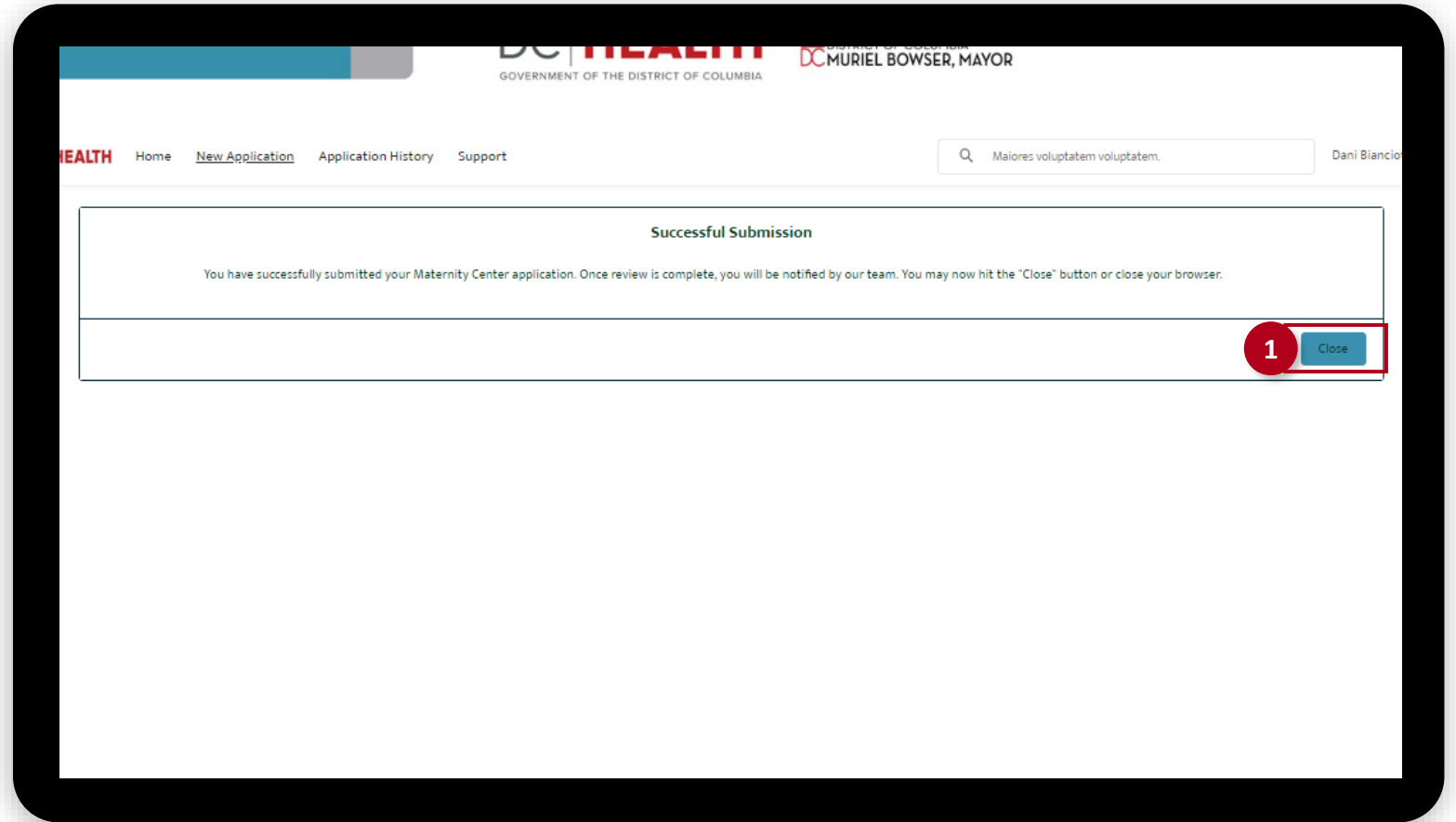


TIP: The date should correspond to today's date.

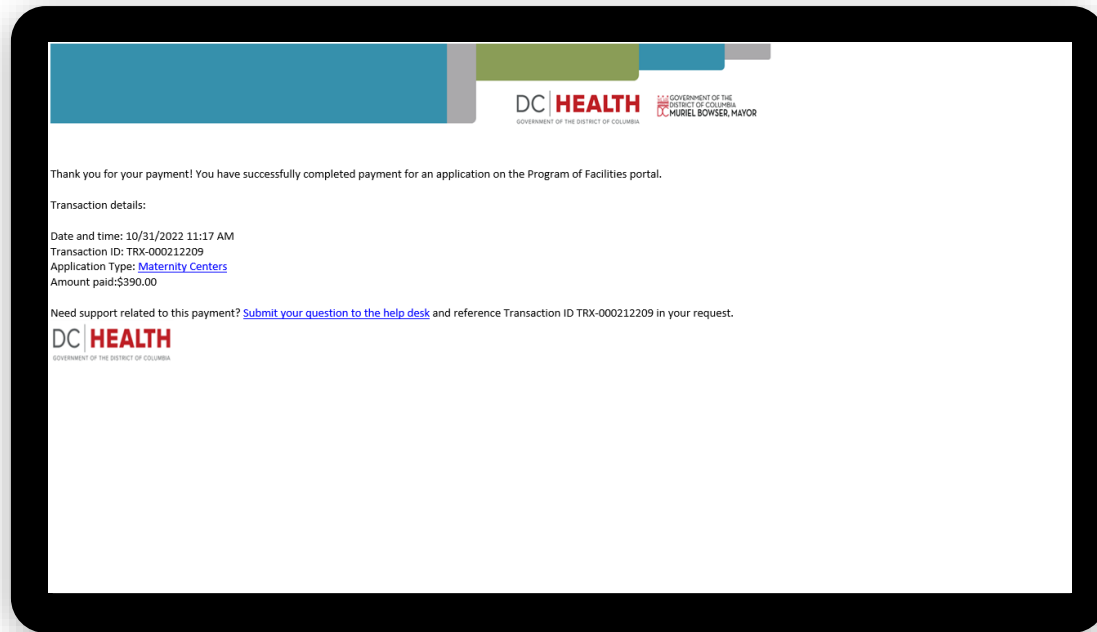
*The fields marked with * are mandatory and must be filled out to continue.*

Close the Application

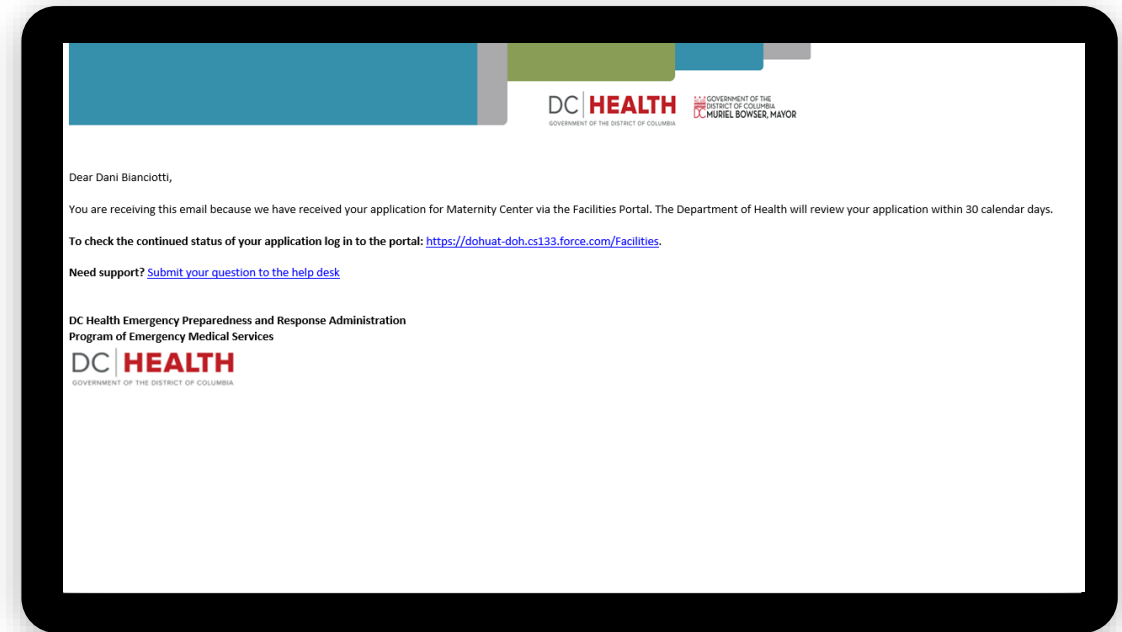
- 1 You have finished submitting your application. Click the **Close** button.



E-mail Confirmation



1 Check if you have received confirmation of payment.



2 Check if you have received confirmation for your application.

Thank you!