DAVID Y. IGE
GOVERNOR OF HAWAII

VIRGINIA PRESSLER, M.D.
DIRECTOR OF HEALTH

In reply, please refer to
file:

STATE OF HAWAII
DEPARTMENT OF HEALTH
OFFICE OF HEALTH CARE ASSURANCE
601 KAMOKILA BOULEVARD, ROOM 337
KAPOLEI, HAWAII 96707

Durable Medical Equipment (DME) Supplier License Application Form and Instructions

Please read carefully to ensure accuracy in completing the application.

General Instructions:

- Complete in full; incomplete forms will be returned as unacceptable. Type or print clearly; illegible forms will be returned as unacceptable.
- Sign documents that have a signature line.
- Only use the application form provided. OHCA will not accept altered application forms.
- Attach documents and provide explanations on additional pages, if needed.

Application Form Instructions:

1. Name of Company and Contact Information: This is the company name and Doing Business As name (DBA), if applicable, as registered in the State of Hawaii or as registered in the company's home state. Include the name, title, and contact information of the company officer responsible for completing this application and complying with Hawaii's licensing requirements. Please check the box that best describes your type of business.

2. Hawaii State Tax Identification Number (GE number): Enter the Hawaii State Tax ID number.

3. Name of Responsible Contact, Mailing Address, Phone Number with Area Code, E-Mail Address: This is the name of the person or agent who will be responsible for providing timely and satisfactory services to consumers during working hours, and the person's or agent's contact information.

4. Include $350.00 License Fee Payment: Verify payment as cashier's check or money order payable to "Director of Finance." Please input "DME License Fee" in the memo section. DO NOT SEND CASH OR PERSONAL CHECK. Payments by credit card cannot be accepted at this time. This fee will be refunded for applications that are deemed unacceptable or not approved. If applicable, please provide the State of Hawaii Board of Pharmacy license number and license expiration date, then check the "Exempt" box.

5. Submission of Documents and Affidavit: Submit the documents, read and agree to the conditions by checking the check boxes, print name, sign, and date.

Submit copies of documents requested. Retain a copy of the application and supporting documents for your own records. Submitted documents will not be returned.

Submit applications to:

State of Hawaii, Department of Health
Office of Health Care Assurance
DME Licensing
601 Kamokila Boulevard, Room 337
Kapolei, Hawaii 96707

Department of Health Office of Health Care Assurance (OHCA)

DURABLE MEDICAL EQUIPMENT (DME) SUPPLIER LICENSE APPLICATION

1. Name of Company:

DBA (if applicable):

Type of Business:

☐ Corporation

☐ Sole proprietorship

☐ Other (Please Explain in space below)

Explanation:

____

2. Hawaii State Tax Identification Number (Attach a copy of the HI State Tax License):

3. Name of Responsible Contact:

Mailing Address:

Phone Number with Area Code:

Email Address:

4. Include License Fee Payment: Include $350.00 (U.S. Dollars Only) in money order or bank or cashier's check payable to "Director of Finance", Memo: DME License Fee. If applicable, please provide the State of Hawaii Board of Pharmacy license number: ______________________ License expiration date: ______________	Method of Payment (Please check one): ☐ Money order ☐ Cashier's check ☐ Exempt

5. Submission of Documents and Affidavit:

If applicable, a copy of current business license in the state in which the applicant is incorporated at and evidence of good standing.

If applicable, a copy of Certificate of Vendor Compliance: Register with Hawaii Compliance Express at the Department of Accounting and General Services (DAGS) website, satisfy all the requirements, and submit a copy of the Certificate of Vendor Compliance. The DAGS website is: https://vendors.ehawaii.gov/hce/splash/welcome.html.

Letter from an officer or executive of the DME supplier designating the named responsible agent or agents either located in or out of Hawaii who shall be responsible for providing timely and satisfactory services to consumers in Hawaii.

Copy of written procedures for handling complaints and problems from consumers. The written procedures shall include procedures for receiving, documenting, and resolving complaints or problems.

I agree:

☐ To notify consumers within two (2) business days if ______________________ cannot or will not provide the equipment, item, or service ordered. (Company Name)

☐ The information provided on this application and supporting documents are complete and accurate.

☐ I have read and fully understand the Licensing announcement letter, Act 137 SLH 2016, and the "State Licensing of Durable Medical Equipment (DME) Suppliers Doing Business in Hawaii, Hawaii State Department of Health Office of Health Care Assurance (OHCA) Policy and Procedure", and agree to comply with all licensing requirements and policies and procedures.

☐ I understand that OHCA may deny my application for a new license or when renewing the license or may revoke or suspend a license when I fail to meet any requirement for licensure specified in Act 137 or in any OHCA policy and procedure related to DME supplier licensing. OHCA policies and procedures relating to DME supplier licensing shall be made available to licensees at http://health.hawaii.gov/ohca/dme.

Name and Title of authorized person:

Name (Print): ______________________________ Title ______________________

Signature: ______________________________ Date: ______________________

All questions and/or concerns must be sent by email to: DOH.OHCAmail@doh.hawaii.gov.