OKLAHOMA STATE DEPARTMENT OF HEALTH
PROTECTIVE HEALTH SERVICES/HEALTH RESOURCES DEVELOPMENT SERVICE
P.O. Box 268823
Oklahoma City, OK 73126-8823
Tel. (405) 271-6868 Fax (405) 271-7360

CERTIFICATE OF NEED APPLICATION FOR EXEMPTION FOR A LICENSED NURSING OR SPECIALIZED FACILITY MANAGEMENT AGREEMENT

I. Name and address of facility affected: ______________________________

____

____

(Area Code) Telephone Number (Area Code) Fax Number

II. Name and address of contact person: ______________________________

____

____

(Area Code) Telephone Number (Area Code) Fax Number

III. Current licensee of facility: ______________________________

IV. Will the licensee for this facility change? [ ]Yes [ ]No If yes, list name(s) of new licensee(s):

____

V. Complete and attach Disclosure Statement, ODH Form 614. The form may be obtained at http://www.health.state.ok.us/program/condiv/laws.html#c.

VI. Pursuant to OAC 310:4-1-13(f)(4), attach *copies of certificates of incorporation, bylaws, articles of organization, company operating agreements, certificates of limited partnership, or equivalent documents maintained pursuant to state or federal law, and any amendments of such documents. Instead of submitting a document that is not a public record previously filed with a local, state or federal government agency, the applicant may submit a sworn and notarized statement that includes all of the following information:*

(A) *Name and date of the document;*
(B) *Name and address of each person or entity that has current or proposed interests, responsibilities or participation in the ownership, operation or management of the facility or that otherwise makes or influences any decision relating to expenditures or operations affecting the facility, whether the person or entity is identified in the disclosed document by proper name or function;*
(C) *Description of the interest, responsibility, and/or nature of participation of each person or entity named pursuant to (f)(4)(B) of this section; and*
(D) *Location and address and telephone number of the place of business in Oklahoma wherein the applicant shall make the document(s) available for inspection by the Department, upon written request by the Department.*

VII. Attach a copy of the proposed management agreement that details the manager's responsibilities and duties.

VIII. Anticipated date of commencement of management agreement: ________________________________

IX. **This form must be accompanied by a $100.00 filing fee. Make checks payable to the Oklahoma State Department of Health.**

I certify that the foregoing is true and complete to the best of my knowledge and belief.

______________________________________	______________________________________
Typed or Printed Name of Person Signing for Applicant	Signature of Applicant
______________________________________	______________________________________
Name of Corporation, Partnership or Association	Official Title or Position

State of ______________________ County of ________________________________

Signed and sworn to (or affirmed) before me on this ______ day of ______________, 20___

____

Name(s) of person(s) making statement.

____

Signature of Notary Public

Seal or Stamp:

My Commission Expires: _____/_______/_____ My Commission Number is:____________