



If the facility mailing address is different - enter the facility mailing address here

4. Name of Administrator: \_\_\_\_\_

Administrator's License Number \_\_\_\_\_. Annual Number \_\_\_\_\_

5. Type of Facility (mark one):  
 Nursing facility  
 Specialized facility for mentally retarded persons  
 Specialized facility for Alzheimer's residents

6. TOTAL NUMBER OF BEDS: \_\_\_\_\_

7. Does the facility advertise, market or otherwise promote itself as providing care or treatment to persons with a diagnosis of Alzheimer's disease or related disorders in a special unit or under a special program?  Yes  No

If "yes," complete and attach ODH 613 Alzheimer's Disease or Related Disorders Special Care Disclosure form.

8. If this is an initial license application, complete and attach forms ODH 953-B Disclosure Statement, 953-C Detail Attachment, 953-D Affirmation Attachment and 953-E Staffing Projection and Professional Certification for a Nursing or Long-Term Care Facility.

9. For initial, renewal or suspended license applications, complete and attach forms ODH 953-G Certification of Compliance for a Nursing or Specialized Facility.

10. If this facility has never been licensed attach a statement from the unit of local government having jurisdiction over the facility's location, confirming that the location of the facility is not in violation of applicable zoning ordinances.

11. Provide name, address and tax identification number of a person or entity who has the legal duties of filing employment tax returns and paying employment taxes with respect to staff required to meet the needs of facility residents. "Staff" includes but is not limited to administrators, nurses, nurse aides, certified medication aides, dietitians, nutritionists, food service staff, qualified mental retardation professionals, and activities, social services, maintenance and housekeeping personnel.

\_\_\_\_\_  
Name of Person or Entity

\_\_\_\_\_  
Tax ID #

\_\_\_\_\_  
Street or Mailing Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

Is the person or entity listed in item 11 a different person or entity than the applicant and licensee?  Yes  No

If "yes," in an attachment describe the relationship between the applicant/licensee and the tax-responsible person or entity and include contracts or organizational documents demonstrating that relationship.

12. Has the applicant or any member if the applicant is a firm, partnership or association, or any officer or majority stockholder if the applicant is a corporation, or any person designated to manage or supervise the facility, been convicted of a felony, meaning a crime that would have a bearing on the operation of a nursing facility? \_\_\_Yes  
\_\_\_No

If "yes," attach a certified copy of the record of the court of conviction.

13. Has there been any changes made since the filing of the last application? \_\_\_ Yes  
\_\_\_ No If "yes," attach ODH forms 953-B Disclosure Statement, 953-C Detail Attachment, 953-D Affirmation Attachment, 953-E Staffing Projection and Professional Certification for A Nursing or Long-Term Care Facility, which discloses and indicates change(s) since the filing of the last application.

**Notice to Applicant: The Nursing Home Care Act requires the applicant to provide, under oath, true and complete information regarding the facility and the applicant. Willfully filing false, incomplete or misleading information is a misdemeanor subject to prosecution by the District Attorney or the Attorney General. In addition, any person willfully providing false, incomplete or misleading information is subject to an administrative penalty of up to \$3,000 per day and suspension, non-renewal or revocation of the facility's license.**

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.

Seal or Stamp:

\_\_\_\_\_  
Signature of Notary Public

My Commission Expires: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

My Commission Number is: \_\_\_\_\_

**NOTICE OF CHANGE (Reference OAC 310:675-3-8(a)):**

After submittal of this application, the applicant has an ongoing responsibility to notify the State Health Department when changes occur. If, after issuance of a license, and before a renewal application is due, changes occur so that information previously submitted in a facility's license application is no longer correct, an ODH Form 958 Notice of Change must be submitted. This includes changes to: facility name, administrator, mailing address, fax number, tax identification number, or other disclosure information of person(s) or entity who has the legal duty of filing employment tax returns and paying employment taxes for facility staff, employment tax filing and payment compliance status, including notification to the Department of any tax warrants, liens, state attachments or federal levies. Notice of Change requirements and forms are available at [www.health.ok.gov/program/condiv/nurs.html](http://www.health.ok.gov/program/condiv/nurs.html).

**RESOURCES:**

Applicable forms, rules and laws for licensure of a nursing facility are available at [www.health.ok.gov/program/condiv/nurs.html](http://www.health.ok.gov/program/condiv/nurs.html). Questions or concerns regarding license applications may be directed to [HealthResources@health.ok.gov](mailto:HealthResources@health.ok.gov), or to the phone number at the top of this form.

***A NON-REFUNDABLE LICENSE FEE MUST ACCOMPANY THIS FORM.***

***FEE — \$10.00 PER LICENSED BED***

***Make check payable to the Oklahoma State Department of Health***