

Agency Name and City: _____ Date: ____/____/____

7. **CONVICTION OF THE APPLICANT(S) OR ANY AFFILIATED PERSON(S)**, for any offense listed in Subsection F of Section 1-1950.1 of Title 63. An application for a license for a home care agency may be denied by the Commissioner of Health for any of the following convictions: assault, battery, or assault and battery with a dangerous weapon; aggravated assault and battery; murder or attempted murder; manslaughter, except involuntary manslaughter; rape, incest or sodomy; indecent exposure and indecent exhibition; pandering; child abuse; abuse, neglect or financial exploitation of any person entrusted to his care or possession; burglary in the first or second degree; robbery in the first or second degree; robbery or attempted robbery with a dangerous weapon, or imitation firearm; arson in the first or second degree; unlawful possession or distribution, or intent to distribute unlawfully, Schedule I through V drugs as defined by the Uniform Controlled Dangerous Substances Act; grand larceny; or petit larceny or shoplifting within the past seven (7) years. Please list all applicants and affiliated persons who have an above listed conviction. Include the type of conviction. If additional space is needed, please provide the required information on an 8.5" x 11" attachment and number the response (7).

_____	_____
(Full Name)	(Type of Conviction)
_____	_____
(Full Name)	(Type of Conviction)
_____	_____
(Full Name)	(Type of Conviction)

8. The full name and address of any legal entity in which the applicant(s) hold(s) a debt or equity interest of at least five percent (5%) or which is a parent company or subsidiary of the applicant(s). *“Subsidiary” means any person, firm, corporation or other legal entity which: (A) controls or is controlled by the applicant, (B) is controlled by an entity that also controls the applicant, or (C) the applicant or an entity controlling the applicant has directly or indirectly the power to control.* [Title 63 O.S. Supp. 1996, Section 1-1965] Include the percentage of ownership. If additional space is needed, please provide the required information on an 8.5" x 11" attachment and number the response (8).

_____	_____	_____
(Full Name)	(Address)	(% of Ownership)
_____	_____	_____
(Full Name)	(Address)	(% of Ownership)
_____	_____	_____
(Full Name)	(Address)	(% of Ownership)

9. The names, locations, and dates of ownership, operation, or management for all current and prior home care agencies owned, operated, or managed in this state or in any other state by the applicant(s) or by any affiliated person(s). Include the percentage of ownership. If additional space is needed, please provide the required information on an 8.5" x 11" attachment and number the response (9).

_____	_____	_____
(Name)	(Address)	(% of Ownership)

(Dates of Ownership, Operation or Management)		
_____	_____	_____
(Name)	(Address)	(% of Ownership)

(Dates of Ownership, Operation or Management)		

10. A description of any ongoing organizational relationships as they may impact operations in the State of Oklahoma which are not identified in #6, #8 or #9. If additional space is needed, please provide the required information on an 8.5" x 11" attachment and number the response (10).

11. **IS AGENCY OR HOSPITAL CURRENTLY CERTIFIED/ACCREDITED** to provide Health Services? Yes___ No___
If yes, indicate the facility's number, effective date, expiration date (if applicable) and certifying or accrediting organization.

Certifying/Accrediting Information: _____

12. **BRANCH OFFICE (S)**. If additional space is needed, please provide the required information on an 8.5" x 11" attachment and number the response (12).

Telephone Number Branch Location (Street Address, City, Zip and Name if Different)

() _____

() _____

13. **CURRENT LIABILITY COVERAGE** Please attach a copy of the certificate of insurance.

Amount per Occurrence: \$ _____ Amount per Aggregate: \$ _____

Expiration Date on Policy: ____/____/____

Carrier: _____

14. **GEOGRAPHICAL AREA WHERE SERVICES ARE PROVIDED:** _____

15. **SERVICES PROVIDED.** Place a "C" on the line if service is contracted and an "E" on the line if service is provided by agency employees.

____ Nursing Care

____ Personal Care

____ Physical Therapy

____ Occupational Therapy

____ Speech Therapy

____ Medical Social Worker

____ Respiratory Therapy

____ Nutritional Guidance

____ Pharmaceutical Infusion Service

____ Appliance and Equipment Service

Other (Please list administrative, clerical, billing or other services) _____

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16. **FULL-TIME EQUIVALENTS (FTE).** List full-time equivalents for each category provided at the time of the application. To arrive at full-time equivalents, add the total number of hours worked by all employees in each classification and divide by the number of hours in the standard work week. If the result for each classification is not a whole number, round up to the nearest quarter (for example .25, .50, .75 or a whole number). Under "All Others" include all other regularly employed personnel (medical and non-medical) that are not included previously.

- | | | | |
|-------|--------------------------|-------|---|
| _____ | Registered Nurse | _____ | Physical Therapist |
| _____ | Licensed Practical Nurse | _____ | Occupational Therapist |
| _____ | Home Health Aide | _____ | Speech Pathologist/ Audiologist |
| _____ | Pharmacist | _____ | Respiratory Therapist |
| _____ | Dietitian | _____ | All Others (administrative, clerical, billing or other) |
| _____ | Medical Social Worker | _____ | Personal Care Assistant (ADvantage Program) |

17. Projected number of visits or shifts per month for six (6) months beginning from the date of application.

Month	Number of Visits/Shifts
1	_____
2	_____
3	_____
4	_____
5	_____
6	_____

18. Evidence of staffing availability sufficient to cover projected visits/shifts. Please provide the required information on an 8.5"x 11" attachment. Please number the response (18).
19. Evidence of financial solvency to include resources sufficient to ensure the agency's ability to provide adequate home care services. The agency shall have an annual operating budget, which ensures sufficient resources to meet operating costs at all times and to maintain standards as required by the Home Care Act and Regulations. Please provide a copy of the annual operating budget and other evidence of financial solvency to establish the ability to provide adequate home care services. Please provide the required information on an 8.5" x 11" attachment and number the response (19).
20. Evidence of the applicant's prior business and professional experience in prior health care provider operations including, but not limited to, nursing homes, residential care homes, home care agencies, and hospices. Please provide the required information on an 8.5" x 11" attachment and number the response (20).
21. The disclosure of compliance history of any person or persons having ownership, operational, management or supervisory authority in the agency. Compliance history disclosure shall include lawful orders of suspension, receivership, administrative penalty or sanction issued by this administrative agency or administrative agencies in other states with similar responsibilities. If additional space is needed, please provide the required information on an 8.5" x 11" attachment and number the response (21).

AGENCY OFFICE HOURS

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
From							
To							

22. SIGNATURE OF APPLICANT(S)

Signature: _____	Signature: _____
Typed Name: _____	Typed Name: _____
Title or Position: _____	Title or Position: _____
Date: ____/____/____	Date: ____/____/____

AFFIDAVIT

STATE OF OKLAHOMA

COUNTY OF _____

On this _____ day of _____, _____ personally appeared before me _____ and _____ whose identity is personally known to me (or proved to me on the basis of satisfactory evidence) and who by me duly sworn (or affirmed), did say that to the best of his/her acknowledge and belief, the statements in the foregoing application are true and correct and that he/she acknowledged that he/she executed it.

Subscribed and sworn to before me _____
Notary Public

My Commission Expires: ____/____/____

FOR USE BY THE OKLAHOMA STATE DEPARTMENT OF HEALTH

Receipt # _____	License # _____	Issued: _____
Amount: \$ _____		Expires: _____
Date: ____/____/____		Changes: _____