

2. **PARENT** Geographic Services Area (by county in alphabetical order). If additional space is needed please number response (2):

3. **PROPOSED BRANCH OFFICE:**

Location Address: _____
(Number & Street) (City) (County) (State) (Zip)

Mailing Address: _____
(Number & Street) (City) (County) (State) (Zip)

Telephone No. () _____ FAX No. () _____

Effective Date: _____

Branch Geographic Services Area (by county in alphabetical order). If additional space is needed please number response (3):

4.

On a separate sheet of paper, please address the items listed below.
please number response (4):
(Please reference each item by the appropriate item number.)

1. Explain how the proposed branch will share supervision with the parent.
2. Explain how the proposed branch will share administration with the parent.
3. Explain how the proposed branch will share services with the parent.
4. Explain how the services provided by the proposed branch will be evaluated for quality of care.
5. List services provided directly and under arrangement.
6. Identify all branch staff and their job title.
7. Provide proof of staff qualifications (license, certification, etc).
8. List all services shared with the home health parent
9. Provide plans for addressing staff absenteeism.
10. Identify any high-tech services provided.
11. Identify how staff will coordinate care and services.
12. Attach an organizational chart delineating lines of authority, professional and administrative control for the home health parent and the branch.

5. 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: _____