

**PROTECTIVE**  
**HEALTH**  
**SERVICES**

**Oklahoma State Department of Health**  
Protective Health Services - 0505  
Medical Facilities  
1000 NE 10th Street  
Oklahoma City, OK 73117-1299  
Telephone: (405) 271-6576  
FAX: (405) 271-1308

**APPLICATION FOR A CHANGE OF OWNERSHIP**  
**LICENSE TO OPERATE AN EXISTING HOME CARE AGENCY**

**INSTRUCTIONS**

- I. Read carefully and complete all portions of the application. **PLEASE TYPE.**
- II. Application for license may be made by the owner, administrative officer, managing agent, or member of the governing body who has responsibility for maintaining approved standards for the institution.
- III. License fee must accompany the application. Checks, money orders, or bank drafts must be made payable to **OKLAHOMA STATE DEPARTMENT OF HEALTH** and mailed to the above address. No such fee shall be refunded. Fee is five hundred dollars (\$500.00) for a **Change of Ownership (CHOW)** to operate an existing home care agency.

**CHOW** Fee for Home Care Agency or Subunit License \$500.00

Fee for \_\_\_\_\_ Branch(es) @ \$25.00 each \_\_\_\_\_

**Total License Fee: \$**

**IV. Any changes are to be reported promptly to the address above.**

The undersigned hereby makes application for license to maintain a home care agency subject to the provisions of the Oklahoma Statutes and to the regulations adopted thereunder by the State Board of Health.

1. **NAME OF AGENCY AT TIME OF PURCHASE:** \_\_\_\_\_

Location Address: \_\_\_\_\_ **License Number:** \_\_\_\_\_  
(Number & Street) (City) (County) (State) (Zip)

2. **OWNERSHIP OF NEW AGENCY\*** (If government entity or corporation, attach names and addresses of Board members and number the response (2).

**ENTITY:** (Name of organization responsible for the operation of the agency) \_\_\_\_\_

**PROJECTED CHANGE OF OWNERSHIP:** Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(Month/Day/Year)

\* **A Change of Ownership (CHOW) requires a copy of the executed sales agreement be provided along with a copy of the authority from the Secretary of State to transact business in Oklahoma, if applicable.**

D.B.A. (If agency operates under another name): \_\_\_\_\_

Telephone Number: ( ) \_\_\_\_\_ Fiscal Year Ending Date: \_\_\_\_/\_\_\_\_  
(Month/Day)

FAX No. ( ) \_\_\_\_\_

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

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

Administrator: \_\_\_\_\_  
(Name) (Administrator's Certificate Number)

Supervising Nurse/Physician: \_\_\_\_\_  
(Name) (License Number)

Alternate  
Supervising Nurse/Physician: \_\_\_\_\_  
(Name) (License Number)

3. \_\_\_\_\_ Sole-proprietorship \_\_\_\_\_ Partnership \_\_\_\_\_ Corporation \_\_\_\_\_ Limited Liability Company (L.L.C.)  
\_\_\_\_\_ Other (State, County, or City Operated Entity, etc.)

4. \_\_\_\_\_ Freestanding Agency \_\_\_\_\_ Hospital-Based Agency

5. **NAME OF PARENT AGENCY:** (if agency is a Subunit) \_\_\_\_\_  
( ) \_\_\_\_\_  
Area Code/Telephone Number Location Address (Street Address, City, State, Zip)

License Number: \_\_\_\_\_ Provider Number: \_\_\_\_\_

6. **APPLICANT'S INFORMATION:** (If government entity or corporation, attach names and addresses of Board members)

a. The full name(s) and address(es) of the new applicant(s). The applicant is the person, corporation, partnership, association or other legal entity under whose ownership the home care agency will be conducted. If additional space is needed, please provide the required information on an 8.5" x 11" attachment and number the response 6(a).

\_\_\_\_\_  
(Full Name) (Address)

\_\_\_\_\_  
(Full Name) (Address)

\_\_\_\_\_  
(Full Name) (Address)

b. The full name(s) and address(es) of person(s) under whose operation, management, or supervision the home care agency will be conducted. If additional space is needed, please provide the required information on an 8.5"x11" attachment and number the response 6(b). Please include the nursing supervisor and alternate nursing supervisor.

\_\_\_\_\_  
(Full Name) (Address)

\_\_\_\_\_  
(Full Name) (Address)

c. The full name(s) and address(es) of all affiliated persons not listed in 6(a) or 6(b). "Affiliated person" means: A) any officer, director or partner of the applicant, (B) any person employed by the applicant as a general or key manager who directs the operations of the facility which is the subject of the application, and (C) any person owning or controlling more than five percent (5%) of the applicant's debt or equity. [63 O.S. Supp. 1996, Section 1-1965] If additional space is needed, please provide the required information on an 8.5"x 11" attachment and number the response 6(c).

\_\_\_\_\_  
(Full Name) (Address)

\_\_\_\_\_  
(Full Name) (Address)

Agency Name and City: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

7. **CONVICTION OF THE NEW 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)

8. The full name and address of any legal entity in which the new 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. [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)

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 new 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)		
(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: \$ \_\_\_\_\_

Carrier: \_\_\_\_\_

Expiration Date on Policy: \_\_\_\_/\_\_\_\_/\_\_\_\_

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) \_\_\_\_\_

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  
\_\_\_\_\_ Licensed Practical Nurse  
\_\_\_\_\_ Home Health Aide  
\_\_\_\_\_ Pharmacist  
\_\_\_\_\_ Dietitian  
\_\_\_\_\_ Medical Social Worker

\_\_\_\_\_ Physical Therapist  
\_\_\_\_\_ Occupational Therapist  
\_\_\_\_\_ Speech Pathologist/ Audiologist  
\_\_\_\_\_ Respiratory Therapist  
\_\_\_\_\_ All Others (administrative, clerical, billing or other)  
\_\_\_\_\_ Personal Care Assistant (ADvantage Program)

Agency Name and City: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**AGENCY OFFICE HOURS**

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
<b>From</b>							
<b>To</b>							

**17. 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: \_\_\_\_\_