

**APPLICATION TO AMEND A
LICENSE TO OPERATE A HOME CARE AGENCY**

INSTRUCTIONS

- I. Read carefully and complete all portions of the application. **Please type or print neatly.**
- II. Application for license may be made by the owner, administrative officer, managing agent, or member of the governing body that has responsibility for maintaining approved standards for the institution.
- III. There is no charge for processing an Application to amend a license.
- IV. Any changes are to be reported promptly to the address above. Relocations **SHALL** notify the Department 30 days prior to the intended relocation by use of this form [310:662-2-1(f)(4)].

The undersigned hereby makes application to amend a 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. **ENTITY:** (Name of organization responsible for operation of agency). License will be issued in this name.

_____ **License Number:** _____
(Name)

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

2. **Only complete the section with changed information:** Parent Branch

New DBA (*Attach registration from Secretary of State): _____

New Administrator: _____ (*Attach copy of Certification)
(Name) (Certificate Number)

New Supervising Nurse/Physician: _____ (*Attach copy of License)
(Name) (License Number)

New Alternate
Supervising Nurse/Physician: _____ (*Attach copy of License)
(Name) (License Number)

New Telephone Number: () _____ New FAX No. () _____

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

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

3. **If you are RELOCATING**, please answer the following questions on a separate sheet of paper & reference each question by the appropriate letter.

- a. Explain the reason for the move.
- b. Are you discharging patients?
- c. Will you continue to serve patients in the current community?
- d. Will you employ the same staff or will you be hiring new staff?
- e. What are the number of miles for the move?
- f. Is it necessary for you to expand your geographic service area to accommodate the move?
- g. Will your phone number change? If yes, will it be long distance for current patients to call?

4. **SERVICES PROVIDED.** Place a "D" if you are deleting the service or an "A" if you are adding the service. Place a "C" on the line if service is contracted and an "E" on the line if service is provided by agency employees. (i.e.... "DC", "DE", "AC", "AE")

____ Nursing Care	____ Personal Care
____ Physical Therapy	____ Occupational Therapy
____ Speech Therapy	____ Medical Social Worker
____ Respiratory Therapy	____ Nutritional Guidance
____ Pharmaceutical Infusion Service	____ Appliance and Equipment Service

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 knowledge 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: ____/____/____