

APPLICATION FOR PRORATED RENEWAL
LICENSE TO OPERATE A 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. The annual fee is five hundred dollars (\$500.00) for a **Renewal License** to operate an existing home care agency or subunit plus twenty-five dollars (\$25.00) for each branch. Fees for renewal licenses prorated to expire on July 31 shall be based on the number of quarters [i.e. three (3) months] or portions thereof for the license. The fee for each quarter or portion thereof shall be one hundred twenty-five dollars (\$125.00) for each parent agency or subunit license and six dollars and twenty-five cents (\$6.25) for each branch license.

Home Care Agency or Subunit License Fee for
_____ Quarters @ \$125.00 each = \$ _____
Branch License Fee for _____ Quarters
@ \$6.25 each = \$ _____ Per Branch Fee
_____ Branch(es) @ Per Branch Fee = \$ _____
Total Prorated 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. **ENTITY: (Name of organization responsible for the operation of the agency).** License will be issued in this name.

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

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

Telephone Number: () _____ Fax Number: () _____

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

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

Administrator: _____
(Name) (Certificate Number)

Supervising Nurse/Physician: _____
(Name) (License Number)

Alternate
Supervising Nurse/Physician: _____
(Name) (License Number)

2. _____ Sole-proprietorship _____ Partnership _____ Corporation _____ Limited Liability Company (L.L.C.)

_____ Other (State, County, or City Operated Entity, etc.)

3. _____ Freestanding Agency _____ Hospital-Based Agency

4. Fiscal Year Ending Date: _____/_____
(Month/Day)

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 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)

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) & 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 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 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 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: \$ _____

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) _____

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

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) |

AGENCY OFFICE HOURS

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
From							
To							

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 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 _____ My Commission Expires: ____/____/____
Notary Public

FOR USE BY THE OKLAHOMA STATE DEPARTMENT OF HEALTH

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