

**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 LEGAL ASSIGNMENT OF A
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. In addition to this Application, provide proof of legal assignment and a copy of the authority from the Secretary of State to do business in Oklahoma.
- 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.

LICENSE NUMBER: _____

1. **NAME OF EXISTING AGENCY:** _____

2. **NEW ENTITY: (Name of organization responsible for the operation of the agency) License will be issued in this name.**

Name: _____

EFFECTIVE DATE OF CHANGE: _____/_____/_____
(Month/Day/Year)

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

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

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 Provider-Based Agency

8. **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 (8).

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

9. 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 applicants 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 (9).

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

10. 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 (10).

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

11. A description of any ongoing organizational relationships as they may impact operations in the State of Oklahoma which are not identified in #7, #9 or #10. If additional space is needed, please provide the required information on an 8.5" x 11" attachment and number the response (11).

12. **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: _____

13. **BRANCH OFFICE(S).** If additional space is needed, please provide the required information on an 8.5" x 11" attachment and number the response (13).

<u>Telephone Number</u>	<u>Branch Location (Street Address, City, Zip and Name if Different)</u>
() _____	_____
() _____	_____

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

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

Expiration Date on Policy: ____/____/____

Carrier: _____

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

16. **SERVICES PROVIDED.** Check if applicable.

- | | |
|---------------------------------------|---------------------------------------|
| _____ 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) _____

17. **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) |

18. **SIGNATURE OF APPLICANT(S)**

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

AGENCY OFFICE HOURS

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
From							
To							

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

Date Received: ____/____/____

Issued: _____

License #: _____

Expires: _____

Changes: _____