

**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 LICENSE TO OPERATE A HOSPICE**

*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. No such fee shall be refunded. License fee shall be determined according to the following table:

**HOSPICE FEE (Check one): STATE LICENSE # \_\_\_\_\_**

- \_\_\_\_\_ Change of Information (no charge) **Change Effective Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_
- \_\_\_\_\_ \$2000.00 Initial License & Application Fee
- \_\_\_\_\_ \$2000.00 Permanent License Fee # \_\_\_\_\_
- \_\_\_\_\_ \$2000.00 Renewal License Fee # \_\_\_\_\_
- \_\_\_\_\_ \$2000.00 Change of Ownership (CHOW) for License # \_\_\_\_\_  
CHOW Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

If CHOW, former hospice name and location: \_\_\_\_\_

- IV. **Initial** Applications must include proof of sufficient financial ability to operate, a narrative summary and a plan of delivery.
- V. **Any changes are to be reported promptly to the address above.**

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

1. **OPERATING ENTITY:** (Name of organization responsible for the operation of the hospice)

Telephone: ( ) \_\_\_\_\_

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

\_\_\_\_\_  
(Name)

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

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

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

*For use by the Oklahoma State Department of Health*

Receipt # \_\_\_\_\_ License Type Hospice # \_\_\_\_\_ Class \_\_\_\_\_ Issued: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Amount \$ \_\_\_\_\_ Expires: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Changes: \_\_\_\_\_

2. **Location Addresses of Alternate Administrative Office(s) operating under this License.** If additional space is needed, please provide the required information on an 8.5" x11.0" attachment. Please number the response (2).

- a) \_\_\_\_\_  
(Number & Street) (City) (County) (State) (Zip)  
Telephone No. ( ) \_\_\_\_\_ FAX No. ( ) \_\_\_\_\_
- b) \_\_\_\_\_  
(Number & Street) (City) (County) (State) (Zip)  
Telephone No. ( ) \_\_\_\_\_ FAX No. ( ) \_\_\_\_\_
- c) \_\_\_\_\_  
(Number & Street) (City) (County) (State) (Zip)  
Telephone No. ( ) \_\_\_\_\_ FAX No. ( ) \_\_\_\_\_

3. **NAME OF HOSPICE ADMINISTRATOR:** \_\_\_\_\_

4. **NAME OF HOSPICE PATIENT CARE COORDINATOR (PCC):** \_\_\_\_\_

5. **NAME OF HOSPICE MEDICAL DIRECTOR:** \_\_\_\_\_

6. **FISCAL YEAR ENDING DATE:** \_\_\_\_\_ / \_\_\_\_\_  
(Month) (Day)

7. **OWNERSHIP OF HOSPICE – NAME OF ENTITY.** Please provide below the name, mailing and finding address of every stockholder (individuals or corporations) with at least 5 percent (5%) ownership interest in the hospice. If additional space is needed, please provide the required information on an 8.5" x11.0" attachment. Please number the response (7).

Percent of Ownership (%)  
Name: \_\_\_\_\_

Finding Address:  
\_\_\_\_\_

Mailing Address:  
\_\_\_\_\_ Percent of Ownership (%)

Name: \_\_\_\_\_

Finding Address:  
\_\_\_\_\_

Mailing Address:  
\_\_\_\_\_

8. **RENEWAL or PERMANENT ONLY:** Please indicate if your plan of delivery has changed.      **NO**      **YES.** If yes, please provide a narrative update explaining how your plan of delivery has changed. Please number the response (8)

9. **TYPE OF CONTROL:**

**Governmental:** State \_\_\_\_\_ County \_\_\_\_\_ City \_\_\_\_\_ City/County \_\_\_\_\_ Hospital Authority or District \_\_\_\_\_

**Non-Governmental Not-for-Profit:** Church Related \_\_\_\_\_ Corporation \_\_\_\_\_ Other(specify) \_\_\_\_\_

**Non-Governmental For Profit:** Individual \_\_\_\_\_ Partnership \_\_\_\_\_ Corporation \_\_\_\_\_ L.L.C. \_\_\_\_\_ Other (specify) \_\_\_\_\_

10. **BOARD OF DIRECTORS.** Attach as an enclosure the Names and Mailing Addresses of each member of the Board of Directors and number the response (10).

11. **SERVICES PROVIDED:** Attach as an enclosure the Name & Mailing Address of each contracted service. Indicate the type of services provided for each contract and number the response (11).

12. **ACCREDITATION-DEEMED STATUS:** If your agency is accredited or deemed please indicate below:

Accredited by: Joint Commission \_\_\_\_\_ CHAP \_\_\_\_\_ Date of expiration: \_\_\_\_\_

Deemed by: Joint Commission \_\_\_\_\_ CHAP \_\_\_\_\_ Date of expiration: \_\_\_\_\_

13. **HOSPICE GEOGRAPHIC AREA.** Please fill in the boxes below of all counties in geographic service area.

- |                                       |  |                                       |  |
|---------------------------------------|--|---------------------------------------|--|
| <input type="checkbox"/> 01 Adair     | <input type="checkbox"/> 21 Delaware   | <input type="checkbox"/> 41 Lincoln   | <input type="checkbox"/> 61 Pittsburg    |
| <input type="checkbox"/> 02 Alfalfa   | <input type="checkbox"/> 22 Dewey      | <input type="checkbox"/> 42 Logan     | <input type="checkbox"/> 62 Pontotoc     |
| <input type="checkbox"/> 03 Atoka     | <input type="checkbox"/> 23 Ellis      | <input type="checkbox"/> 43 Love      | <input type="checkbox"/> 63 Pottawatomie |
| <input type="checkbox"/> 04 Beaver    | <input type="checkbox"/> 24 Garfield   | <input type="checkbox"/> 44 McClain   | <input type="checkbox"/> 64 Pushmataha   |
| <input type="checkbox"/> 05 Beckham   | <input type="checkbox"/> 25 Garvin     | <input type="checkbox"/> 45 McCurtain | <input type="checkbox"/> 65 Roger Mills  |
| <input type="checkbox"/> 06 Blaine    | <input type="checkbox"/> 26 Grady      | <input type="checkbox"/> 46 McIntosh  | <input type="checkbox"/> 66 Rogers       |
| <input type="checkbox"/> 07 Bryan     | <input type="checkbox"/> 27 Grant      | <input type="checkbox"/> 47 Major     | <input type="checkbox"/> 67 Seminole     |
| <input type="checkbox"/> 08 Caddo     | <input type="checkbox"/> 28 Greer      | <input type="checkbox"/> 48 Marshall  | <input type="checkbox"/> 68 Sequoyah     |
| <input type="checkbox"/> 09 Canadian  | <input type="checkbox"/> 29 Harmon     | <input type="checkbox"/> 49 Mayes     | <input type="checkbox"/> 69 Stephens     |
| <input type="checkbox"/> 10 Carter    | <input type="checkbox"/> 30 Harper     | <input type="checkbox"/> 50 Murray    | <input type="checkbox"/> 70 Texas        |
| <input type="checkbox"/> 11 Cherokee  | <input type="checkbox"/> 31 Haskell    | <input type="checkbox"/> 51 Muskogee  | <input type="checkbox"/> 71 Tillman      |
| <input type="checkbox"/> 12 Choctaw   | <input type="checkbox"/> 32 Hughes     | <input type="checkbox"/> 52 Noble     | <input type="checkbox"/> 72 Tulsa        |
| <input type="checkbox"/> 13 Cimarron  | <input type="checkbox"/> 33 Jackson    | <input type="checkbox"/> 53 Nowata    | <input type="checkbox"/> 73 Wagoner      |
| <input type="checkbox"/> 14 Cleveland | <input type="checkbox"/> 34 Jefferson  | <input type="checkbox"/> 54 Okfuskee  | <input type="checkbox"/> 74 Washington   |
| <input type="checkbox"/> 15 Coal      | <input type="checkbox"/> 35 Johnston   | <input type="checkbox"/> 55 Oklahoma  | <input type="checkbox"/> 75 Washita      |
| <input type="checkbox"/> 16 Comanche  | <input type="checkbox"/> 36 Kay        | <input type="checkbox"/> 56 Okmulgee  | <input type="checkbox"/> 76 Woods        |
| <input type="checkbox"/> 17 Cotton    | <input type="checkbox"/> 37 Kingfisher | <input type="checkbox"/> 57 Osage     | <input type="checkbox"/> 77 Woodward     |
| <input type="checkbox"/> 18 Craig     | <input type="checkbox"/> 38 Kiowa      | <input type="checkbox"/> 58 Ottawa    |  |
| <input type="checkbox"/> 19 Creek     | <input type="checkbox"/> 39 Latimer    | <input type="checkbox"/> 59 Pawnee    |  |
| <input type="checkbox"/> 20 Custer    | <input type="checkbox"/> 40 LeFlore    | <input type="checkbox"/> 60 Payne     | <input type="checkbox"/> Entire State    |

14. **If you are RELOCATING**, please answer the following questions on a separate sheet of paper. Please number the response (14) and 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?

**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: \_\_\_\_/\_\_\_\_/\_\_\_\_