Medical Facilities
Protective Health Services

Oklahoma State
Department of Health

Oklahoma State Department of Health
Protective Health Services
Medical Facilities Service
Home Services Division
Phone: (405) 271-6576
Fax: (405) 271-1141

APPLICATION FOR LICENSE TO OPERATE A HOME CARE AGENCY

1. APPLICATION TYPE & LICENSE FEE: *No such fee shall be refunded.*

License fee must accompany the application. Checks, money orders, or bank drafts must be made payable to ***OKLAHOMA STATE DEPARTMENT OF HEALTH*** and mailed with your completed application.

OKLAHOMA STATE DEPARTMENT OF HEALTH
FINANCIAL MANAGEMENT - RECEIPTING UNIT
PO BOX 268823
OKLAHOMA CITY, OK 73126-8823

_____	$ 1000.00	Initial License & Application Fee
_____		Prorated Fee ($125.00 per Quarter x _____ Quarters = License Fee)
_____	$ 500.00	Renewal License Fee
_____		Branch Renewal Fee ($25.00 per Branch x _____)
_____	$ 500.00	Change of Ownership (CHOW) Effective Date: _____
$ 0		TOTAL

If CHOW, former name and location: _____
_____

_____ **(No Charge)** Change of Information Effective Date: _____

Prorated Fee Note: The annual fee is five hundred dollars ($500.00) for a **Renewal License** to operate an existing home care agency or 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 license and six dollars and twenty-five cents ($6.25) for each branch license.

2. REQUIRED ATTACHMENTS:

Applicants must include the following documents based on the application type

Initial Application/CHOW Application	*Change of Information Application*	*Renewal/Prorated Renewal Application*
1. Application for license to operate a Home Care 2. Application Fee (Nonrefundable) 3. Secretary of State authority to operate 4. Financial Solvency 5. Staff Availability 6. Plan of Delivery (scope & range of service) 7. Administrator certification verification 8. Supervising and Alternate supervisor License verification 9. Certificate of Insurance verification 10. Workers' Compensation verification 11. Attached response to #11, #12(a, b, c), #13(a, b, c) 12. Authorized signature for application completion	1. Application for license to operate a Home Care #1, #2, #3, #4, #5, #6 2. Provide the area(s) being changed (as an attached response with the selected item # response affected/being changed.) 3. Include supporting documentation for the change	1. Application for license to operate a Home Care 2. Application Fee (Nonrefundable) 3. Secretary of State authority to operate 4. Plan of Delivery (scope & range of service 5. Administrator certification verification 6. Supervising and Alternate supervisor License verification 7. Certificate of Insurance verification 8. Workers' Compensation verification 9. Attached response to #11, #12(a, b, c), #13(a, b, c),

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 there under by the State Board of Health.

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

_____ License#: _____
(Name) *(if chow/renewal)*

D.B.A. _____
(Please attach PROOF the Entity and/or D.B.A. names are registered and match the Oklahoma Secretary of State website in accordance with Title 18 §22-1130 - 1140.)

4. ENTITY BUSINESS FORMAT/TYPE: _____
(Sole Proprietorship, Limited Liability Company, Cooperative, Corporation, Partnership, etc.)

5. PHYSICAL ADDRESS: _____
(Number & Street) *(City)* *(County)* *(State)* *(Zip)*

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

6. ADMINISTRATOR: _____
(PRINTED NAME – Provide Copy of Certification)

Email Address: _____

Supervising Nurse/ Physician:_____

Alt. Supervising Nurse/Physician:_____

Phone: _____ Agency after hrs. #: _____ Fax: _____

7. AGENCY OFFICE HOURS:

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
From							
To							

8. GEOGRAPHIC AREA: Identify desired/current County Service area(s) below. Please provide an attachment of any partial county service by city on an 8.5" x 11" attachment and number the response (8).

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

9. **ACCREDITATION-DEEMED STATUS:** If your agency is deemed; indicate the accrediting organization and the date of expiration.

Deemed by: Joint Commission ____ CHAP ____ ACHC ____ Date of expiration: _____

10. SERVICES PROVIDED. You must select one of the following for the corresponding service in the columns below: ***Contract or Employee***

SERVICE	PROVIDER	SERVICE	PROVIDER	SERVICE	PROVIDER
Nursing Care		Respiratory Therapy		Speech Therapy	
Physical Therapy		Occupational Therapy		Appliance/Equipment Service	
Home Health Aid		Pharmaceutical Infusion		Dietician/Nutrition Services	
Medical Social Worker		Sitter/Companion Service		OTHER: Administrative, clerical, billing, etc.	
Medicaid Waiver (Advantage) Case Management				Medicaid Waiver (Advantage) Personal Care	

==========

11. BRANCH OFFICE(S). Provide each branch location(s) address, city, zip code and telephone number associated with this license on a separate 8.5" x 11" attachment. Number attachment **11**.

12. OWNERSHIP OF AGENCY:

12(a). Provide name, mailing and finding address of every stockholder [individual(s) or corporations] with at least five percent (5%) ownership interest in the Home Care agency. Include the percentage (%) owned for this entity. Provide the required information as an 8.5" x 11" attachment. Number Attachment **12(a).**

12(b). Full name(s), title, and address of person(s) under whose operation, management, or supervision the Home Care agency will be conducted. Please provide the required information on an 8.5" x 11" attachment. Number Attachment **12(b).**

12(c). The full name(s) and address of all affiliated persons not listed in 12(a) or 12(b). "Affiliated Person" means:

i.) Any officer, director or business partner of the applicant,

ii.) Any person employed by the applicant as a general or key manager who directs the operations of the entity which is the subject of the application,

iii.) 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]. Provide the required information as an 8.5" x 11" attachment. Number Attachment **12(c).**

13. BUSINESS PERCENTAGES OWNED:

13(a). Provide the full name of entity, address, and percentage of interest of any legal entity in which the applicant(s) hold(s) a debtor 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: (i) controls or is controlled by the applicant, (ii) is controlled by an entity that also controls the applicant, or (iii) the applicant or an entity controlling the applicant has directly or indirectly the power to control.* [Title 63 O.S. Supp. 1996, Section 1-1965]. Please provide the required information on an 8.5" x 11" attachment. Number Attachment **13(a).**

13(b). Provide the names, locations, and dates of ownership, operation, or management for all current and prior home care related agencies owned, operated, or managed in this state or in any other state by each applicant(s) or by any affiliated person(s). Include the percentage of ownership. Please provide the required information on an 8.5" x 11" attachment. Number the response **13(b).**

13(c). Provide a description of any ongoing organizational relationships which may impact operations in the State of Oklahoma that are not identified in 12(a)(b)**.** Please provide the required information on an 8.5" x 11" attachment. Number the response **13(c).**

14. RELOCATION: If your agency is relocating. Please provide answers to the following questions on an 8.5" x 11" attachment. Number attachment **14**.

a. Explain the reason for the move.
b. Are you discharging patients?
c. Will you employ the same staff or will you be hiring new staff?
d. What is the number of miles being move from present location?
e. Is it necessary for you to extend your geographic service area to accommodate the move?
f. Will your phone number change? If yes, will it be long distance for current patients to call?

15. CONVICTIONS:

(LIST CONVICTIONS OF THE APPLICANT(s) OR ANY AFFILIATED PERSON(s))

Any offense listed in Subsection F of Section 1-1950.1 of Title 63. An application for a license for a sitter-companion 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. ***List all applicants and affiliated persons who have an above listed conviction. Include the type of conviction.*** Please provide the required information on an 8.5" x 11" attachment. Number attachment **15.**

==========

By my signature below, I certify that the foregoing is true and correct to the best of my knowledge and belief and also certify that I am not less than twenty-one (21) years of age; of reputable and responsible character; in sound physical and mental health. If the applicant is a firm, partnership or corporation, the applicant shall not be eligible to be licensed if any member of the firm or partnership or any officer or major stockholder has been convicted of a felony cited for any offense listed in Subsection F of Section 1-1950.1 of Title 63.

SIGNATURE OF APPLICANT(S)

Signature: _____ Typed Name: _____

Title or Position: _____ Date: _____

Signature: _____ Typed Name: _____

Title or Position: _____ Date: _____

CLEAR SAVE PRINT

DETAILS FOR COMPLETING APPLICATION SECTIONS NUMBERED FOR LICENSE TO OPERATE A HOME CARE AGENCY

1. **APPLICATION TYPE & LICENSE FEE:** Select the Application type. If CHOW is selected, list the prior name of the entity.

2. **REQUIRED ATTACHMENTS:** This is a list of the attachments that are required for a completed application.

3. **ENTITY:** The Entity name is the name for which the license will be issued, if the entity has a doing business name this should be provided with a copy of the Secretary of State Trade Name Report.

4. **ENTITY BUSINESS FORMAT/TYPE:** List the business type (i.e. Sole Proprietorship, Limited Liability Company, Cooperative, Corporation, Partnership, or other).

5. **PHYSICAL ADDRESS:** Physical address is the actual location of the business (please note an agency cannot be located in a home). The mailing address should identify where you would like any correspondence to be mailed.

6. **ADMINISTRATOR:** List the Certified Administrator that will be in charge of the agency and provide a copy of certification (provide proof of experience if this is a new application/change of Administrator).**List the Supervising Nurse/Physician** and the **Alternate Supervising Nurse/Physician** List (provide proof of licensure). List the email address where entity correspondence should be sent. Include the telephone number, after hours number, and fax number for the entity.

7. **AGENCY OFFICE HOURS:** List the business office hours for the entity under the selected days of the week. (Note: the after hour telephone number must be available during non-business hours.)

8. **GEOGRAPHIC AREA:** Indicate the geographic extent of the entity's operation, by checking the space preceding the appropriate service area(s) by county. Indicate whether the agency provides service in less than an entire county of the selected items (such as a city or portion of a county).

9. **ACCREDITATION-DEEMED STATUS**

10. **SERVICES PROVIDED:** List a "C" for areas where the agency is providing the service using Contract Staff. List an "E" for areas where the agency uses its own staff to provide services.

11. **BRANCH OFFICE(S):** Provide the location (address, city, zip code, and phone number) information, for all branches associated with the license listed on this application.

12. **OWNERSHIP OF AGENCY: (a)** List the name, mailing address, and finding address of every owner/stockholder with greater than 5% ownership interest in the entity listed in section 3 of this application; on a separate 8.5" x 11" attachment. Also include individuals, corporations and Board member names, titles and finding address on a separate 8.5" x 11" attachment; for government and corporation entities (such as Sole-proprietorship, partnership, corporation).

12b. List the name, title, and finding address of those who will be responsible for managing the entity.

12c. List the name of any affiliated person with decision making ability for the entity listed in section 3 of this application; that have not previously been identified in item #12a, #12b, or #12c.

13. **Business Percentages: (a)** List the name, address, and percentage of ownership of each entity that the applicant(s) have affiliation and/or ownership interest. Provide the list for each affiliate and applicant.

13b. List any previously owned/ affiliated health related entities for the applicant on a separate 8.5" x 11" attachment.

13c. List any organizational affiliation or relationships that might affect the entity's operation in the State of Oklahoma.

14. **RELOCATION:** This information should be provided if the agency is changing location. Provide detailed responses in reference to questions 14. a-f.

15. **CONVICTIONS:** List any affiliate or owner who have one of the designated convictions identified in item #15. Provide the name of the applicant/affiliate, and conviction on a separate 8.5" x 11" attachment

Do not forget the required signatures for completion of the application.