



Medical Facilities  
 Protective Health Services  
 Oklahoma State  
 Department of Health

Oklahoma State Department of Health  
 Medical Facilities Services  
 Attn: Financial Mgmt Receiving Unit  
 PO Box 268823  
 Oklahoma City, OK 73126-8816  
 Telephone: (405) 271-6576  
 FAX: (405) 271-1308

**APPLICATION FOR A HOSPICE**  
**ALTERNATE ADMINISTRATIVE OFFICE (AAO)**  
**INSTRUCTIONS**

1. Read carefully and complete all portions of the application. Please type or print legibly.
2. Application may be made by the owner, administrative officer, managing agent, or member of the governing body has responsibility for maintaining approved standards for the institution.
3. There is a non-refundable fee i/a/o \$500.00 to apply for addition of a Hospice Alternative Administrative Office. This fee **must** accompany your **application** and be mailed to the following address:  
 OSDH, Financial Mgmt - Receiving Unit, PO Box 268823, Oklahoma City, OK 73126-8816.
4. The AAO shall be located within a geographical area with a radius of no more than 50 miles from the main hospice.
5. The AAO shall be operated under the same administration and governing body as an extension site for services of the main hospice.
6. The AAO shall operate under the same name(s) as the licensee.

*The undersigned hereby makes application to add a hospice sub-location 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)**

Medicare Provider No. \_\_\_\_\_ State License No. \_\_\_\_\_

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

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

Telephone No. ( ) \_\_\_\_\_ Fax No. ( ) \_\_\_\_\_

Administrator: \_\_\_\_\_

Geographic Service Area of Main Office (by county):  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**2. ALTERNATE ADMINISTRATIVE OFFICE INFORMATION:** Proposed Effective Date: \_\_\_\_\_

Name: \_\_\_\_\_ (Required to be the same as the parent)

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

Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

**Geographic Service Area of AAO-** must be within the area serviced by the main office (by county):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

***Indicate available services & how services are provided:***

As related to the Hospice, place a (C) Contract, (V) Volunteer, or (E) Employee in each column below

	Parent	AAO		Parent	AAO
Nursing Services			Drugs & Biological		
Physical Therapy			Occupational Therapy		
Speech Therapy			Medical Social Services		
Home Health Aide			Homemaker Services		
Dietary Counseling by Reg. Dietician			Medical Supplies		
Counseling Services (Pastoral or other)			Short-term inpatient acute care Where:		
Physician Services			Short-term inpatient respite care Where:		
Bereavement Counseling			Medical Appliances (DMEs)		

**3.** On separate papers, please provide a narrative explanation of how services are provided at the Hospice Alternate Administrative Office (AAO) related to the following:

1. Coordination & continuity of care
2. Supervision of services
3. Patient care planning
4. Role & function of interdisciplinary group (IDG)
5. Informed consent
6. Clinical records
7. Compliance with accepted practices
8. Patient Rights

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

Signature: \_\_\_\_\_

Signature: \_\_\_\_\_

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

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

Title or Position: \_\_\_\_\_

Title or Position: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

DO NOT WRITE BELOW THIS LINE

Recommendation: Approved \_\_\_\_\_ Denied \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

(Oklahoma State Department of Health Representative)