



Medical Facilities  
Protective Health Services

Oklahoma State  
Department of Health

**Oklahoma State Department of Health**

Protective Health Services  
Medical Facilities Service  
Home Services Division

Telephone: (405) 271-6576  
FAX: (405) 271-1308

**APPLICATION FOR LICENSE TO OPERATE A  
SITTER OR COMPANION SERVICE AGENCY**

- I. Read carefully and complete all portions of the application. **PLEASE TYPE or PRINT NEATLY**
- 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 with your completed application.

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

No such fee shall be refunded.

\_\_\_\_\_ Change of Information (no charge) Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 \_\_\_\_\_ \$1000.00 Initial License & Application Fee  
 \_\_\_\_\_ \$500.00 Renewal License Fee  
 \_\_\_\_\_ \$500.00 Change of Ownership (CHOW) Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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

- IV. Any changes are to be submitted on this form and mailed promptly to the following address:  
**Medical Facilities Service, Home Services Division, 1000 NE 10<sup>th</sup> Street, Oklahoma City, OK 73117-1299.**

The undersigned hereby makes application for license to maintain a Sitter-Companion agency subject to the provisions of the Oklahoma Statutes and to the regulations adopted there under 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# \_\_\_\_\_  
 (Name)

D.B.A. \_\_\_\_\_  
 (If agency operates under another name. Please attach a copy of the Trade Name Report):

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

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

Email Address: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

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

2. Fiscal Year Ending Date Month \_\_\_\_\_ Year \_\_\_\_\_

3. \_\_\_\_\_ Sole-proprietorship \_\_\_\_\_ Partnership \_\_\_\_\_ Corporation \_\_\_\_\_ Limited Liability Company (L.L.C.)  
 \_\_\_\_\_ Other (City, County, or State Operated Entity) \*Please attach a copy of the authority from the SECRETARY OF STATE to transact business in Oklahoma (if applicable).

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

Amount per Occurrence: \$ \_\_\_\_\_ Amount per Aggregate: \$ \_\_\_\_\_

Expiration Date on Policy: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Carrier: \_\_\_\_\_

5. **WORKERS' COMPENSATION:** Please attach proof of participation in a workers' compensation insurance program for employees who are subject to pertinent labor laws.

6. **PLAN OF DELIVERY:** Attach a copy of the agency's plan of delivery that describes the scope and range of companion or sitter services available to clients and their families as well as a description of the system of record keeping that meets the requirements specified in the Act.

7. **RENEWAL APPLICANTS ONLY.** Has there been a change to the PLAN OF DELIVERY? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please attach a copy of the update plan of delivery to reflect the changes.

8. **SERVICE AREA:** Attach a copy of the counties you will be providing sitter services.

**AGENCY OFFICE HOURS**

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
<b>From</b>							
<b>To</b>							

9. **APPLICANT'S INFORMATION:** (If government entity or corporation, attach names and addresses of Board members)

a. The full name(s) and address of the applicant(s). The applicant is the person, corporation, partnership, association or other legal entity under whose ownership the sitter-companion 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 9(a).

\_\_\_\_\_  
 (Full Name) (Address)

\_\_\_\_\_  
 (Full Name) (Address)

\_\_\_\_\_  
 (Full Name) (Address)

b. The full name(s) and address 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" x 11" attachment and number the response 9(b).

\_\_\_\_\_  
 (Full Name) (Address)

\_\_\_\_\_  
 (Full Name) (Address)

\_\_\_\_\_  
 (Full Name) (Address)

c. The full name(s) and address of all affiliated persons not listed in 9(a) & 9(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 9(c).

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

\_\_\_\_\_  
(Address)

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

\_\_\_\_\_  
(Address)

**10. CONVICTION 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. 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 (10).

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

\_\_\_\_\_  
(Type of Conviction)

11. 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.* [Title 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 (11).

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

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(% of Ownership)

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

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(% of Ownership)

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

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(% of Ownership)

12. The names, locations, and dates of ownership, operation, or management for all current and prior sitter-companion 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 (12).

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

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(% of Ownership)

\_\_\_\_\_  
(Dates of Ownership, Operation or Management)

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

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(% of Ownership)

\_\_\_\_\_  
(Dates of Ownership, Operation or Management)

13. A description of any ongoing organizational relationships as they may impact operations in the State of Oklahoma which are not identified in #9, #10 #11 or #12. If additional space is needed, please provide the required information on an 8.5" x 11" attachment and number the response (13).

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

14. The disclosure of compliance history of any person or persons having ownership, operational, management or supervisory authority in the agency. Compliance history disclosure shall include lawful orders of suspension, receivership, administrative penalty or sanction issued by this administrative agency or administrative agencies in other states with similar responsibilities. If additional space is needed, please provide the required information on an 8.5" x 11" attachment and number the response (14).

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

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; and have not been convicted of a felony, meaning a crime that would have a bearing on the operation of a sitter-companion agency. I attest to providing individual service plans, conducting criminal background checks and all other requirements of sections 310:662-8(1-7).

**SIGNATURE OF APPLICANT(S)**

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

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

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

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

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

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

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

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

**For use by the Oklahoma State Department of Health**

Receipt # \_\_\_\_\_ Issued: \_\_\_\_/\_\_\_\_/\_\_\_\_ Amount \$ \_\_\_\_\_

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