



**Medical Facilities
Protective Health Services**

**Oklahoma State
Department of Health**

Medical Facilities Service
Home Services Division
Protective Health Services
Telephone: (405) 271-6576
FAX: (405) 271-1141

Email: medicalfacilities@health.ok.gov
Website: <http://mfs.health.ok.gov>

**APPLICATION FOR INITIAL LICENSE TO OPERATE
A HOME CARE AGENCY BRANCH**

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** and submitted with your completed application to the following address: OSDH, ATTN: FINANCIAL MANAGEMENT RECEIPTS UNIT, PO BOX 268823, OKLAHOMA CITY, OK 73126-8823. No such fee shall be refunded.
The **Branch License** fee is Twenty-Five dollars (\$25.00) for each branch office of a home care agency.

_____ Number of Branches x \$25.00 =
Total License Fee: \$ _____

- IV. **Any change of licensure information are to be reported promptly to:**
Medical Facilities Service, Home Services Division, 1000 NE 10th Street, Oklahoma City, OK 73117-1299
Please note: If mailing a fee with an application, you must use the Post Office Box address listed above in item No. III.

The undersigned hereby makes application for license to maintain a home care agency branch 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)

_____ **License Number:** _____

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

Telephone No. (____) _____ FAX No. (____) _____

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

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

Administrator: _____
(Name) (Certificate Number)

Supervising Nurse/Physician: _____
(Name) (License Number)

Alternate Supervising Nurse/Physician: _____
(Name) (License Number)

2. BRANCH OFFICE(S). If additional space is needed, please provide the required information on an 8.5" x 11.0" attachment. Please number the response (2).

Phone Number	Branch Location (Street Address, City, Zip and Name if Different)
(____) _____	_____
(____) _____	_____
(____) _____	_____

3. On a separate sheet of paper, please address the items listed below.
Please number your response (3.) Please reference each item by the appropriate item number.

1. Explain how the proposed branch will share supervision with the parent.
2. Explain how the proposed branch will share administration with the parent.
3. Explain how the proposed branch will share services with the parent.
4. Explain how the services provided by the proposed branch will be evaluated for quality of care.
5. List services provided directly and under arrangement.
6. Identify all branch staff and their job title.
7. Provide proof of staff qualifications (license, certification, etc).
8. List all services shared with the home health parent.
9. Provide plans for addressing staff absenteeism.
10. Identify any high-tech services provided.
11. Identify how staff will coordinate care and services.
12. Attach an organizational chart delineating lines of authority, professional and administrative control for the home health parent and the branch.

4. 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. 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 as cited for any offense listed in Subsection F of Section 1-1950.1 of Title 63.

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 # _____	License # _____	Issued: ____/____/____	Expires: _____
Amount \$ _____	Date: ____/____/____	Changes: _____	