



Medical Facilities  
Protective Health Services

Oklahoma State  
Department of Health

Oklahoma State Department of Health

Protective Health Services  
Medical Facilities Services

Telephone: (405) 271-6576

FAX: (405) 271-1308

## **APPLICATION FOR LICENSE TO OPERATE A HOME CARE AGENCY**

### **INSTRUCTIONS**

- 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. **RELOCATION:** Must notify OSDH **30 days** prior to the relocation. Please answer the following questions, **on separate paper**. Please provide the required information on an 8.5" x 11" attachment and number the response (15).
  - 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 numbers 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?

Checks, money orders, or bank drafts must be made payable to the OKLAHOMA STATE DEPARTMENT OF HEALTH and SUBMITTED WITH YOUR COMPLETED APPLICATION to the following address:

**OSDH, ATTN: FINANCIAL MANAGEMENT – RECEIPTS UNIT  
FOR: PHS-MEDICAL FACILITIES  
PO BOX 268823  
OKLAHOMA CITY, OK 73126-8823**

No such fee shall be refunded.

Home Care Fee (check one): STATE LICENSE # \_\_\_\_\_

- \_\_\_\_\_ \$1000.00 Initial License & Application Fee
- \_\_\_\_\_ \$500.00 Renewal License Fee
- \_\_\_\_\_ \$500.00 Change of Ownership (CHOW) Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_
- \_\_\_\_\_ \$25.00 Fee (initial, renewal, or CHOW) for Branch(es) \$\_\_\_\_\_

Total License Fee: \$ \_\_\_\_\_

- \_\_\_\_\_ Change of Information (No Charge) Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_
- ( ) Parent ( ) Branch (Complete the sections of the form with the changes)

- I. Any changes are to be reported promptly to the address above.
- II. **Change of Ownership (CHOW)** Shall be filed at least **30 days** prior to the effective date of the change along with the fee & copy of the executed sales agreement.
  - a. Name of Agency at time of Purchase: \_\_\_\_\_
  - b. New Entity Ownership: \_\_\_\_\_  
(If government entity or corporation attach names and addresses of Board Members and number the response 16)
  - c. New D.B.A. (if operating under another name) \_\_\_\_\_

1. **Legal Entity:** \_\_\_\_\_  
(Name of organization responsible for the operation of the agency)

**D.B.A. (Operates under another name)** \_\_\_\_\_  
(include a copy of the Trade Name report from the Secretary of State, if applicable)

NOTE: Attach a copy of the Trade Name Report from the Oklahoma Secretary of State's Office, if applicable.

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

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

**EMAIL ADDRESS: (REQUIRED)** \_\_\_\_\_

**Telephone No. of this location:** ( ) \_\_\_\_\_ **Fax:** ( ) \_\_\_\_\_

**Administrator (Attach a copy of certification):** \_\_\_\_\_

<b>Supervising RN / Physician:</b> _____	(Name)	(Certificate Number)
(Attach a copy of license verification)	(Name)	(License Number)

<b>Alternate Supervising RN / Physician:</b> _____	(Name)	(License Number)
(Attach a copy of license verification)	(Name)	(License Number)

**Medical Director(s) (if applicable):** \_\_\_\_\_

2. \_\_\_\_\_ Sole-proprietorship \_\_\_\_\_ Partnership \_\_\_\_\_ Corporation \_\_\_\_\_ Limited Liability Company (L.L.C.)  
\_\_\_\_\_ Other (State, County, or City Operated Entity, etc.) \_\_\_\_\_ Freestanding Agency \_\_\_\_\_ Hospital-Based Agency



b. 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 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 8(a).

(Full Name)	(Address)
(Full Name)	(Address)
(Full Name)	(Address)

c. The full name(s) and address of the 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"x11" attachment and number the response 8(b). Please include the nursing supervisor and alternate nursing supervisor.

(Full Name)	(Address)
(Full Name)	(Address)
(Full Name)	(Address)

d. The full name(s) and address of all affiliated persons not listed in 8(a) & 8(b). *“Affiliated person” means: 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 8(c).

(Full Name)	(Address)
(Full Name)	(Address)
(Full Name)	(Address)

9. 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.* [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 (9).

(Full Name)	(Address)	(% of Ownership)
(Full Name)	(Address)	(% of Ownership)

**10. CONVICTION OF THE APPLICANT(S) OR ANY AFFILIATED PERSON(S)**, for any offense listed in Subsection F of Section 1-1950.1 of Title 63. An application for a license for a home care 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)
(Full Name)	(Type of Conviction)

**11.** The names, locations, and dates of ownership, operation, or management for all current and prior home care 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 (11).

(Name)	(Address)	(% of Ownership)
(Dates of Ownership, Operation or Management)		
(Name)	(Address)	(% of Ownership)
(Dates of Ownership, Operation or Management)		

**12.** A description of any ongoing organizational relationships as they may impact operations in the State of Oklahoma which are not identified in #8, #9 or #11. If additional space is needed, please provide the required information on an 8.5" x 11" attachment and number the response (12).

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**AGENCY OFFICE HOURS**

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

**13. SERVICES PROVIDED.** Place a "C" on the line if service is contracted and "E" on the line if service is provided by agency employee.

- |   |                                 |                               |
|---|---------------------------------|-------------------------------|
| _____ Nursing Care  | _____ Personal Care             | _____ Physical Therapy        |
| _____ Occupational Therapy  | _____ Speech Therapy            | _____ Medical Social Worker   |
| _____ Respiratory Therapy   | _____ Nutritional Guidance      | _____ Pharmaceutical Infusion |
| _____ Appliance and Equipment Service   | _____ Sitter/Companion Services |                               |
| _____ Other (Please list administrative, clerical, billing or other services) _____ |                                 |                               |

**14. FULL-TIME EQUIVALENTS (FTE).** List full-time equivalents for each category provided. To arrive at full-time equivalents, add the total number of hours worked by all employees in each classification, and divide by the number of hours in the standard work week. If the result for each classification is not a whole number, round up to the nearest quarter (for example .25, .50, .75 or a whole number). Under "All Others" include all other regularly employed personnel (medical and nonmedical) that are not included previously.

- |                                |   |
|--------------------------------|---|
| _____ Registered Nurse         | _____ Physical Therapist                                      |
| _____ Licensed Practical Nurse | _____ Occupational Therapist                                  |
| _____ Home Health Aide         | _____ Speech Pathologist/Audiologist                          |
| _____ Pharmacist               | _____ Respiratory Therapist                                   |
| _____ Dietician                | _____ All Others (administrative, clerical, billing or other) |
| _____ Medical Social Worker    | _____ Personal Care Assistant (ADvantage Program)             |

**15. RELOCATION:** Must notify OSDH 30 days prior to the relocation. Please answer the following questions. If additional space is needed, please provide the required information on an 8.5" x 11" attachment and number the response (15).

- 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 is 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?

**16. INITIAL/CHOW APPLICANTS:** Evidence of staffing availability sufficient to cover projected visits/shifts. Please provide the required information on an 8.5" x11" attachment. Please number the response (16).

**17. INITIAL/CHOW APPLICANTS:** Evidence of financial solvency to include resources sufficient to ensure the agency's ability to provide adequate home care services. The agency shall have an annual operating budget, which ensures sufficient resources to meet operating costs at all times and to maintain standards as required by the Home Care Act and Regulations. Please provide a copy of the annual operating budget and other evidence of financial solvency to establish the ability to provide adequate home care services. Please provide the required information on an 8.5" x11" attachment and number the response (17).

**18. INITIAL/CHOW APPLICANTS:** Evidence of the applicant's prior business and professional experience in prior health care provider operations including, but not limited to, nursing homes, residential care homes, home care agencies, and hospices. Please provide the required information on an 8.5" x11" attachment and number the response (18).

**19.** 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: ____/____/____

**IMPORTANT NOTE:**

**All REQUIRED FEES MUST BE SUBMITTED WITH YOUR APPLICATION TO THE ADDRESS BELOW:**

**OKLAHOMA STATE DEPARTMENT OF HEALTH  
ATTN: FINANCIAL MANAGEMENT – RECEIPTS UNIT  
FOR: PHS-MEDICAL FACILITIES  
PO BOX 268823  
OKLAHOMA CITY, OK 73126-8823**

**PLEASE REFERENCE YOUR LICENSE NUMBER AND NAME OF YOUR AGENCY ON YOUR CHECK.**

*FOR USE BY THE OKLAHOMA STATE DEPARTMENT OF HEALTH*

<b>Date:</b> ____/____/____	<b>Receipt #</b> _____	<b>Amount:</b> \$ _____
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<b>License #</b> _____	<b>Issued:</b> ____/____/____	<b>Expires:</b> ____/____/____
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**Changes:**

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