

# INSTRUCTIONS for Assisted Living Center or Continuum of Care Renewal License Application

Most responses are to be provided in the form of individual attachments. Start by providing a list of your attachments. Label the attachments so they correspond with each item in the instructions.

Make checks payable to the Oklahoma State Department of Health. Submit fee, ODH Form 624, and applicable attachments to:

Health Resources Development Service  
Health Facility Systems  
Oklahoma State Department of Health  
P.O. Box 268823  
Oklahoma City, OK 73126-8823

**The Continuum of Care and Assisted Living Act, at Title 63 O.S. Section 1-890.4, provides fees as follows:**

- 1) Each application to establish a continuum of care facility or assisted living center shall be accompanied by a non-refundable application fee of Ten Dollars (\$10.00) for each bed included in the maximum bed capacity at such facility center. The maximum application fee for each facility or center shall be One Thousand Dollars (\$1000). The application fee for establishment of a facility or center shall be in addition to the license fee required under the Act and OAC 310:663-21-4(b).
- 2) Each application for an initial license or annual renewal of the license to operate a continuum of care facility or an assisted living center shall be accompanied by a license fee of Ten Dollars (\$10.00) for each bed included in the maximum bed capacity at such facility or center. An additional fee of Seventy-five Dollars (\$75) shall accompany a facility that includes an adult day care service.
- 3) The application and license fee shall be paid by check to the Oklahoma State Department of Health.
- 4) The fee for a license amendment to reflect a change in bed capacity shall be prorated based on the number of days remaining until the current license expires, and the number of beds being added.
- 5) Application submittals which do not require a fee should be submitted to:  
Health Resources Development Service  
Health Facility Systems  
Oklahoma State Department of Health  
1000 N.E. 10th Street  
Oklahoma City, Oklahoma 73117-1207  
Or by facsimile: 405-271-7360
- 6) The State Health Department is located at 1000 N.E. 10<sup>th</sup> Street, Oklahoma City, OK 73117-1207.
- 7) **DEADLINES FOR FILING APPLICATION FOR LICENSE** [OAC 310:663-21-1, 21-2, and 27-1 and 2]

**General requirements:**

- The effective date of filing shall be the date the application and fee are received by the Department.
- The person or entity responsible for providing or arranging all required services and care should be the applicant for the license.
- Any substantial change in the information originally reported in the license application shall be submitted to the Department for review.

**Renewal:** Application for renewal must be filed by the expiration date specified on the existing license.

# Application Inventory

(Return with application-Check each item submitted)

- Application signed by person listed on owner information page attached, and notarized.** OAC 310:663-21-1(b)
- Application Filing Fee (*\$10.00 per licensed bed*). 63 O.S. 1-890.4(B)
- State Fire Marshal Inspection Report (dated within the last twelve (12) months). OAC 310:663-21-5(C) and OAC 310:663-21-5(b)(7)
- Copy of the Administrator's current license or page showing administrator licensed from OSBELTCA Website. OAC 310:663-21-5(c)(2) and OAC 310:663-21-5(b)(2) (<http://www.ok.gov/osbeltca>)
- Secretary of State Website sheet (documentation licensee is active, and manager, if applicable). 63 O.S. 1-890.5 Print and submit page showing entity is active. <http://204.87.112.123:81/home/home-default.asp> or <https://www.sos.ok.gov/corp/corpInquiryFind.aspx>
- Summary of the Resident grievance and dispute resolution activities for the previous twelve (12) months. **Do not provide documentation that includes residents' names.** OAC 310:663-21-5(c)(2)
- Does the facility provide Alzheimer's disease special care as defined in 63-1-879.2b(1)?  
\_\_\_ Yes \_\_\_ No

If "yes", the Alzheimer's disease or related Disorders Special Care Disclosure statement ([ODH Form 613](#)) is submitted. 63 O.S. 1-879.2a and OAC 310:663-21-5(b)(3)(c)(1) (<http://hfs.health.ok.gov>)

- Disclose the number of residents who reside in the assisted living center which are not capable of responding to emergency situations with physical assistance from staff or are not capable of self-preservation. If the facility has none or will not admit residents who are not capable of responding to emergency situations without physical assistance from staff, indicate "0". \_\_\_Residents. OAC 310:663-21-5(c)(1)
- Has the information listed on the Owner Information changed? \_\_\_Yes \_\_\_No

If "yes", provide changes to owner information on the attached owner information page or the [ODH 953-B](#) and/or [953-C](#), to detail all changes. 63 O.S. 1-890.4(c)(1) and OAC 310:663-21-5(c)

- Have changes occur which affect the information submitted from the previous application for license or in the information originally reported in the license? \_\_\_Yes \_\_\_No

If you answered "yes" to above, provide the material which has been changed and indicate change(s) from previous submitted.

The End





Health Resources  
Development Service  
Oklahoma State  
Department of Health

Health Facility Systems  
P.O. Box 268823  
Oklahoma City, OK 73126-8823  
Phone 405.271.6868  
Fax 405.271.7360  
E-mail [HealthResources@health.ok.gov](mailto:HealthResources@health.ok.gov)  
Web <http://hfs.health.ok.gov>

## ASSISTED LIVING CENTER LICENSE APPLICATION

**RENEWAL LICENSE:**     WITHOUT CHANGES     WITH CHANGES

Facility License Number: \_\_\_\_\_

1. Name of Licensee: \_\_\_\_\_
2. Name of Facility: \_\_\_\_\_
3. Facility Fax number: \_\_\_\_\_
4. Name of Facility's Contact Person: \_\_\_\_\_
5. Facility Contact Person's telephone number: \_\_\_\_\_

**NOTE: IF THERE ARE NO CHANGES OR UPDATES TO THE APPLICATION, COMPLETE THE APPLICATION INVENTORY SHEET AND SIGN AND NOTARIZED BELOW.**

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I certify the information provided in this application and attachments are true and complete to the best of my knowledge and belief.

\_\_\_\_\_  
Typed or Printed Name of Person Signing for Applicant

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Name of Corporation, Partnership or Association

\_\_\_\_\_  
Official Title or Position

State of \_\_\_\_\_

County of \_\_\_\_\_

Signed and sworn to (or affirmed) before me on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Name(s) of person(s) making statement.

\_\_\_\_\_  
Signature of Notary Public

Seal or Stamp

My Commission Expires: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

My Commission Number is: \_\_\_\_\_

