

Street or Mailing Address

City

State

Zip

In an attachment, describe the relationship between the applicant/licensee and the tax-responsible person or entity and include contracts or organizational documents demonstrating that relationship.

2. Facility Name (d.b.a. name): _____

NOTE: Medicare nursing facilities must submit a CMS-855A to the fiscal intermediary for initial certification, change of ownership and information changes (i.e., name or address change). The "legal name" on your CMS-855A and the "operating entity name" on your license must match exactly. The "d.b.a." (doing business as) name on your CMS-855A and the facility name on your license must match exactly. Failure to complete the CMS-855A process may affect Medicare payments.

3. Location of Facility: _____
Street City State Zip

County Fax Number Telephone Number

4. Provide the name, address, telephone number, fax number, and e-mail address of the facility's contact person. (This is the individual with whom the Department should communicate.)

Name Telephone Number

E-Mail Address Fax Number

Mailing Address City State Zip

5. Administrator Name: _____ License Number: _____

Manager Name: _____

6. Facility License Type (**check only one**):

- Nursing Facility
- Specialized Facility for Individuals with Intellectual Disabilities*
- Specialized Facility for Alzheimer's Residents

7. TOTAL NUMBER OF BEDS: _____

8. Does the facility advertise, market, or otherwise promote itself as providing care or treatment to persons with a diagnosis of Alzheimer's disease or related disorders in a special unit or under a special program?

Yes No

If "yes," complete and attach ODH Form 613, *Alzheimer's Disease or Related Disorders Special Care Disclosure*.

9. If this is an initial license application, complete and attach ODH Forms: 953-B, *Disclosure Statement*; 953-C, *Detail Attachment*; 953-D, *Affirmation Attachment*; and 953-E, *Staffing Projection and Professional Certification for a Nursing or Long-Term Care Facility*.

* The term "the Mentally Retarded" has been replaced in this form with "Individuals with Intellectual Disabilities" in accordance with CMS guidance and Oklahoma Statutory authority. Reference the [Federal Register, 77 FR 29003, 29021-29022, 29028, 42 CFR Section 400.203](#), and [Title 25 Oklahoma Statutes Section 40](#). The proposed term amendment will be addressed in future rulemaking activity.

10. If this facility has never been licensed, attach a statement from the unit of local government having jurisdiction over the facility's location, confirming that the location of the facility is not in violation of applicable zoning ordinances.

11. Has the applicant or any member, if the applicant is a firm, partnership, or association, or any officer or majority stockholder; if the applicant is a corporation or any person designated to manage or supervise the facility been convicted of a felony, meaning a crime that would have a bearing on the operation of a nursing facility?

___ Yes ___ No

If "yes," attach a certified copy of the record of the court of conviction.

NOTICE OF CHANGE [OAC 310:675-3-8(a)]

After submittal of this application, the applicant has an ongoing responsibility to notify the State Health Department when changes occur. **If changes occur after issuance of a license and before a renewal application is due, so that previously submitted information in a facility's license application is no longer correct, an ODH Form 958, Notice of Change must be submitted.** This includes changes to: facility name, administrator, mailing address, fax number, tax identification number, or other disclosure information of person(s) or entity who has the legal duty of filing employment tax returns and paying employment taxes for facility staff, employment tax filing and payment compliance status. Notice of Change requirements and forms are available at <http://hfs.health.ok.gov>.

NOTICE TO APPLICANT AND OATH STATEMENT

The Nursing Home Care Act requires the applicant to provide, under oath, true and complete information regarding the facility and the applicant. Willfully filing false, incomplete, or misleading information is a misdemeanor subject to prosecution by the District Attorney or the Attorney General. In addition, any person willfully providing false, incomplete or misleading information is subject to an administrative penalty of up to \$3,000 per day and suspension, non-renewal or revocation of the facility's license.

I certify the foregoing is 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.

Seal or Stamp

Signature of Notary Public

My Commission Expires: _____ / _____ / _____

My Commission Number is: _____

RESOURCES: Applicable forms, rules and laws for licensure of a nursing facility are available at <http://hfs.health.ok.gov>. Questions of concerns regarding license applications may be directed to HealthResources@health.ok.gov or to phone number (405) 271-6868.