



LICENSE APPLICATION FOR A NURSING OR SPECIALIZED FACILITY

REQUIREMENT FOR LICENSE (63 O.S. § 1-1903) *No person shall establish, operate or maintain in this state any nursing facility without first obtaining a license as required by the Nursing Home Care Act. Violators are subject to penalties.*

FEE (63 O.S. § 1-1905) *A. An application for a license, or renewal thereof, to operate a facility shall be accompanied by a fee of Ten Dollars (\$10.00) for each bed per year included in the maximum bed capacity at such facility. Effective July 1, 2016, nursing facility licenses will be renewed every three years. Total fee=(number of beds) x (\$10.00) x (3 years). Your fee should accompany this form. Make check payable to the Oklahoma State Department of Health.*

DEADLINES FOR FILING APPLICATION (OAC 310:675-3-2.1)

New facility: Application for initial license must be filed at least thirty (30) days before operating a facility. An initial license is issued for 180 days. The fee will be calculated for half of one year. Fee = (# of beds) x (\$10.00) x (0.5 years).

Change of ownership or operation: Application for initial license must be filed at least thirty (30) days before the final transfer of the facility.

Renewal: Application for renewal must be filed on or before expiration date on the existing license.

Suspended: Application for suspended license must be filed within thirty (30) days after relocation of all residents or within thirty (30) days after the date the facility ceases operation.

This application is submitted for the following review (mark one):

- | | | |
|--|---|--|
| <input type="checkbox"/> Initial license | <input type="checkbox"/> Renewal license | <input type="checkbox"/> Renewal license w/ changes
<i>(Attach Notice of Change, ODH Form 958)</i> |
| <input type="checkbox"/> Amendment to current license
<i>(Attach Notice of Change, ODH Form 958)</i> | | <input type="checkbox"/> Suspended license |

Facility License Number (assigned by OSDH): _____

1. Applicant/Licensee Name: _____

For Renewal of License only: Have there been any changes from the previously submitted application and supporting documents? Yes No.

If NO, proceed to Notice to Applicant and Oath Statement. If YES, please complete and attach an ODH Form 958, Notice of Change.

Is the licensee the responsible party who has the legal duty of paying and filing employment taxes of facility staff?
 Yes No If 'No', complete the following information.

Provide name, address, and tax identification number of the person or entity with the legal duty of paying and filing employment taxes of facility staff. **This is the name of the person, or entity, and tax id # listed on the top of IRS Form 940 and 941 (typically the licensee).**

Name of Person or Entity Tax ID

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.

