Print Form

Health Resources Development Service

Oklahoma State Department of Health

Health Facility Systems
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DISCLOSURE STATEMENT

Owner, Lessee, Manager for a Long-Term Care Facility

http://hfs.health.ok.gov

This Disclosure Statement is being submitted for the following type of review:

☐ **Initial license** ☐ **Amendment to previous filing** ☐ **Renewal license** ☐ **Suspended license**

1. Facility Identification

Facilty ID Number: _____

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

2. Owner(s)/Lessor(s) of Building, Land and Equipment Information

A. Name of Owner(s)/Lessor(s): _____

_____ _____ _____ _____
Street Address City State Zip Code

Phone _____ Fax _____

B. If this Entity is a Government Entity, check the type that applies.

☐ **Public Trust Authority** ☐ **County** ☐ **City** ☐ **State**

C. Complete *Detail Attachment to the Disclosure Statement* (ODH Form 953-C) for the Owner(s)/Lessor(s), as an attachment to **2C**.

3. Lessee Information If the lease includes sub-leases, complete for all parties.

Is the facility leased? ☐ **Yes** ☐ **No** If "yes", continue. If "no", skip to No. 4.

A. Name of Lessee: _____

_____ _____ _____ _____
Street Address City State Zip Code

Phone _____ Fax _____

B. If this Entity is a Government Entity, check the type that applies.

☐ **Public Trust Authority** ☐ **County** ☐ **City** ☐ **State**

C. Complete ODH Form 953-C for the Lessee, as an attachment to **3C**.

4. Manager/Supervisor Information

Does the licensee contract with a manager or supervisor (as defined in OAC 310:675-1-2) to perform management or administrative services? ☐ **Yes** ☐ **No**

If "yes", continue. This requires certificate of need approval or exemption approval. If "no", skip to No. 5.

A. Name of Manager/Supervisor: _____

_____ _____ _____ _____
Street Address City State Zip Code

Phone _____ Fax _____

B. If this Entity is a Government Entity, check the type that applies.

☐ **Public Trust Authority** ☐ **County** ☐ **City** ☐ **State**

C. Complete ODH Form 953-C, Detail Attachment for the Manager/Supervisor, as an attachment to **4C**.

5. Affirmation

Submit a copy of the *Affirmation Attachment to the Disclosure Statement* (ODH Form 953-D) for each person who holds an interest or position, as described in the instructions of ODH Form 953-C.

6. Have there been changes in the following? (Check all that apply and provide the effective date.)

☐ **Owner/lessor** Effective Date of Change _____

☐ **Lessee** Effective Date of Change _____

☐ **Manager/Supervisor** Effective Date of Change _____

Notice to Applicant

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 that 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 Person Signing for 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

Notary Public Signature _____

Seal or Stamp

Notary Commission Number _____

Commission Expires _____