Oklahoma State Department of Health
Protective Health Services
Medical Facilities Service
Home Services Division
Phone: (405) 426-8470
Fax: (405) 900-7559

APPLICATION FOR LICENSE TO OPERATE A HOSPICE AGENCY

1. APPLICATION TYPE & LICENSE FEE: *No such fee shall be refunded.*

License fee must accompany the application. Checks, money orders, or bank drafts must be made payable to ***OKLAHOMA STATE DEPARTMENT OF HEALTH*** and mailed with your completed application.

OKLAHOMA STATE DEPARTMENT OF HEALTH FINANCIAL MANAGEMENT - RECEIPTING UNIT PO BOX 268823 OKLAHOMA CITY, OK 73126-8823

	$ 2000.00	Initial License & Application Fee	
	$ 2000.00	Renewal License Fee	License #: _____
	$ 50.00	Late Fee	
	$ 500.00	Alternate Adminstrative Office (AAO)	($500 X _____ Per AAO)
	$ 2000.00	Change of Ownership (CHOW)	Effective Date: _____
		If CHOW, list former name and location: _____	
$ 0	**TOTAL**	_____	
	(No Charge)	Change of Information (CHOI)	Effective Date : _____

NOTE: OAC 310: 661-2-3. "*The **effective date** shall be the date a complete application and fee are received. All fees shall be non-refundable.*"
OAC 310: 661-2-6 (d). "*A **late renewal fee** of fifty dollars ($50.00) shall be charged for any hospice submitting an application for renewal within thirty (30) days after the expiration date of the license.*"

2. REQUIRED ATTACHMENTS:

Applicants must include the following documents based on the application type

Initial Application/CHOW Application	*Change of Information Application*	*Renewal/Prorated Renewal Application*
1. Application for license to operate a Hospice complete in entirety. 2. Application Fee (Nonrefundable) 3. Secretary of State authority to operate 4. Financial Solvency (Initial App Only) 5. Narrative Summary (Initial App Only) 6. Plan of Delivery (scope & range of service) 7. Administrator & Supervising RN credential verification 8. Attached response to #13, #14(a, b, c), #15(a, b, c), and 17 9. Authorized signature for application completion 10. Executed Sales Agreement (CHOW ONLY)	1. Application for license to operate a Hospice #1, #2, #3, #4, #5, #6 2. Provide the area(s) being changed (as an attached response with the selected item # response affected/ being changed.) 3. Include supporting documentation for the change 4. (If relocating complete #16)	1. Application for license to operate a Hospice complete in entirety. 2. Application Fee (Nonrefundable) 3. Secretary of State authority to operate 4. Plan of Delivery (scope & range of service) 5. Patient Care Coordinator License verification 6. Attached response to #13, #14(a, b, c), #15(a, b, c), 17.

The undersigned hereby makes application for license to maintain a Hospice agency subject to the provisions of the Oklahoma Statutes and to the regulations adopted there under by the State Board of Health.

3. ENTITY: *(Name of organization responsible for the operation of the agency)* **License will be issued in this name.**

_____ License#: _____
(Name)

D.B.A. _____
(Please attach PROOF the Entity and/or D.B.A. names are registered and match the Oklahoma Secretary of State website in accordance with Title 18 §22-1130 - 1140.)

4. ENTITY BUSINESS FORMAT/TYPE, CONTROL: [ ]

5. PHYSICAL ADDRESS: _____
(Number & Street) (City) (County) (State) (Zip)

Mailing Address: _____
(Number & Street) (City) (County) (State) (Zip)

6. ADMINISTRATOR: _____
(PRINTED NAME)

Email Address: _____

Patient Care Coordinator (PCC): _____ License#: _____

Medical Director: _____ License#: _____

Phone: _____ Agency after hrs. #: _____ Fax: _____

7. AGENCY OFFICE HOURS:

	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
From							
To							

8. GEOGRAPHIC AREA: Identify desired/current County Service area(s) below. Please provide an attachment of any partial county service by city on an 8.5" x 11" attachment and number the response (8).

❑ 01 Adair	❑ 21 Delaware	❑ 41 Lincoln	❑ 61 Pittsburg
❑ 02 Alfalfa	❑ 22 Dewey	❑ 42 Logan	❑ 62 Pontotoc
❑ 03 Atoka	❑ 23 Ellis	❑ 43 Love	❑ 63 Pottawatomie
❑ 04 Beaver	❑ 24 Garfield	❑ 44 McClain	❑ 64 Pushmataha
❑ 05 Beckham	❑ 25 Garvin	❑ 45 McCurtain	❑ 65 Roger Mills
❑ 06 Blaine	❑ 26 Grady	❑ 46 McIntosh	❑ 66 Rogers
❑ 07 Bryan	❑ 27 Grant	❑ 47 Major	❑ 67 Seminole
❑ 08 Caddo	❑ 28 Greer	❑ 48 Marshall	❑ 68 Sequoyah
❑ 09 Canadian	❑ 29 Harmon	❑ 49 Mayes	❑ 69 Stephens
❑ 10 Carter	❑ 30 Harper	❑ 50 Murray	❑ 70 Texas
❑ 11 Cherokee	❑ 31 Haskell	❑ 51 Muskogee	❑ 71 Tillman
❑ 12 Choctaw	❑ 32 Hughes	❑ 52 Noble	❑ 72 Tulsa
❑ 13 Cimarron	❑ 33 Jackson	❑ 53 Nowata	❑ 73 Wagoner
❑ 14 Cleveland	❑ 34 Jefferson	❑ 54 Okfuskee	❑ 74 Washington
❑ 15 Coal	❑ 35 Johnston	❑ 55 Oklahoma	❑ 75 Washita
❑ 16 Comanche	❑ 36 Kay	❑ 56 Okmulgee	❑ 76 Woods
❑ 17 Cotton	❑ 37 Kingfisher	❑ 57 Osage	❑ 77 Woodward
❑ 18 Craig	❑ 38 Kiowa	❑ 58 Ottawa	
❑ 19 Creek	❑ 39 Latimer	❑ 59 Pawnee	
❑ 20 Custer	❑ 40 LeFlore	❑ 60 Payne	❑ ENTIRE STATE

9. **ACCREDITATION-DEEMED STATUS:** If your agency is deemed; indicate the accrediting organization and the date of expiration.

Deemed by: Joint Commission ____ CHAP ____ ACHC ____ Date of expiration: _____

10. **ALTERNATE ADMINISTRATIVE OFFICE(S) (AAO).** Provide each AAO location(s) address, city, zip code and telephone number associated with this license on a separate 8.5" x 11" attachment. Number the response **(10).**

11. **NARRATIVE SUMMARY:** Attach a list that includes the name, mailing address, and type of services for each contracted service. Number the response **(11).**

12. **PLAN OF DELIVERY:** List all services provided by the agency. Number the response **(12).**

13. **BOARD OF DIRECTORS.** Attach as an enclosure the Names and Mailing Addresses of each member of the Board of Directors. Number the response **(13).**

==========

14. **OWNERSHIP OF AGENCY:**

14(a). Provide name, mailing and finding address of every Owner/stockholder [individual(s) or corporations] with at least five percent (5%) ownership interest in the Hospice agency. Provide the required information as an attachment. Number the response **(14a).**

14(b). Full name(s), title, and address of person(s) under whose operation, management, or supervision the Hospice agency will be conducted. Please provide the required information on an attachment. Number the response **(14B).**

14(c). The full name(s) and address of all affiliated persons not listed in 14(a) or 14(b). "Affiliated Person" means:
i.) Any officer, director or business partner of the applicant,
ii.) Any person employed by the applicant as a general or key manager who directs the operations of the entity which is the subject of the application,
iii.) 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]. Provide the required information as an attachment. Number the response **(14c).**

15. **BUSINESS PERCENTAGES OWNED:**

15(a). Provide the full name of entity, address, and percentage of interest of any legal entity in which the applicant(s) hold(s) a debtor 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: (i) controls or is controlled by the applicant, (ii) is controlled by an entity that also controls the applicant, or (iii) the applicant or an entity controlling the applicant has directly or indirectly the power to control. [Title 63 O.S., Section 1-860.6]. Please provide the required information as an attachment. Number the response **(15a).**

15(b). Provide the names, locations, and dates of ownership, operation, or management for all current and prior hospice related agencies owned, operated, or managed in this state or in any other state by each applicant(s) or by any affiliated person(s). Include the percentage of ownership. Please provide the required information on an attachment. Number the response **(15b)**.

15(c). Provide a description of any ongoing organizational relationships which may impact operations in the State of Oklahoma that are not identified in 15(a)(b). Please provide the required information on an attachment. Number the response **(15c).**

16. **RELOCATION:** If your agency is relocating. Please provide answers to the following questions on an attachment. Number the response **(16).**

a. Explain the reason for the move.
b. Are you discharging patients?
c. Will you employ the same staff or will you be hiring new staff?
d. What is the number of miles for the move?
e. Is it necessary for you to extend your geographic service area to accommodate the move?
f. Will your phone number change? If yes, will it be long distance for current patients to call?
g. Will your phone number change? If yes, will it be long distance for current patients to call?

17. CONVICTIONS:

(LIST CONVICTIONS OF THE APPLICANT(s) OR ANY AFFILIATED PERSON(s))

Any offense listed in Subsection F of Section 1-1950.1 of Title 63. An application for a license for a Hospice 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. ***List all applicants and affiliated persons who have an above listed conviction. Include the type of conviction.*** Please provide the required information on an 8.5" x 11" attachment. Number attachment **(17).**

==========

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; and have not been convicted of a felony, meaning a crime that would have bearing on the operation of a Hospice Agency. I attest to providing individual service plans, conducting criminal background checks and all other requirements of sections 310:661-3-2 (n).

Must print and sign the printed copy for submission.

SIGNATURE OF APPLICANT(S)

Signature: _____ Typed Name: _____

Title or Position: _____ Date: _____

Signature: _____ Typed Name: _____

Title or Position: _____ Date: _____

CLEAR SAVE PRINT

DETAILS FOR COMPLETING APPLICATION SECTIONS NUMBERED FOR LICENSE TO OPERATE A HOSPICE

1. **APPLICATION TYPE & LICENSE FEE:** Select the Application type. If CHOW is selected, list the prior name of the entity. If completing a Change of information provide a brief description of the change. Be sure to note effective dates if a CHOW/ CHOI

2. **REQUIRED ATTACHMENTS:** This is a list of the attachments that are required for a completed application.

3. **ENTITY:** The Entity name is the name for which the license will be issued, if the entity has a Doing Business (DBA) name this should be provided with a copy of the Secretary of State Trade Name Report.

4. **ENTITY BUSINESS FORMAT/TYPE:** List the business type (i.e. Sole Proprietorship, Limited Liability Company, Cooperative, Corporation, Partnership, or other).

5. **PHYSICAL ADDRESS:** Physical address is the actual location of the business (please note an agency cannot be located in a home). The mailing address should identify where you would like any correspondence to be mailed. Include the telephone number, after hour number, and fax number for the entity.

6. **ADMINISTRATOR:** List the Administrator that will be in charge of the agency (provide proof of experience if this is a new application/ change of Administrator). List the Patient Care Coordinator (PCC). List the email address where entity correspondence should be sent. Include the telephone number, after hour number, and fax number for the entity. PCC Must rpovide verifiaction of License.

7. **ALTERNATE ADMINISTRATIVE OFFICES (AAO):** Provide the location (address, city, zip code, and phone number) information, for all AAOs associated with the license listed on this application.

8. **AGENCY OFFICE HOURS:** List the business office hours for the entity under the selected days of the week. (Note: the after hour number must be available during non-business hours).

9. **ACCREDITATION:** Indicate if your agency is accredited, and select the accrediting organization noting the expiration date.

10. **GEOGRAPHIC AREA:** Indicate the geographic extent of the entity's operation, by checking the space preceding the appropriate service area(s) by county. Indicate whether the agency provides service in less than an entire county of the selected items (such as a city or portion of a county).

11. **NARRATIVE SUMMARY:** List the name, and mailing address, and type of service provided for in each contracted service. Provide proof of Patient Right's Notification & Advisement of Charges (Initial Application Only)

12. **PLAN OF DELIVERY:** Provide a narrative explaining the Plan of Delivery of the home and inpatient hospice services to the patients and their families, listing all services that will be provided by the agency.

13. **BOARD OF DIRECTORS:** List individual members (include legal name, address, phone number, and title) who are elected or appointed to jointly oversee the activities of the agency listed in this application.

14. **OWNERSHIP OF AGENCY:**

    a. List the name, mailing address, and finding address of every owner/stockholder with greater than 5% ownership interest in the entity listed in section 3 of this application; as an attachment. Also include individuals and corporations and Board member names, titles and finding address as an attachment; for government and corporation entities (such as Sole-proprietorship, partnership, corporation).

    b. List the name, title, and finding address of those who will be responsible for managing the entity.

    c. List the name of any affiliated person with decision making ability for the entity listed in section 3 of this application; that have not previously been identified in item #14a, #14b, or #14c.

15. **BUSINESS PERCENTAGES:**

    a. List the name, address, and percentage of ownership of each entity that the applicant(s) have affiliation and/or ownership interest. Provide the list for each affiliate and applicant.
    b. List any previously owned/ affiliated health related entities for the applicant as an attachment.
    c. List any organizational affiliation or relationships that might affect the entity's operation in the State of Oklahoma.

16. **RELOCATION:** This information should be provided if the agency is changing location. Provide detailed responses in reference to questions #a-#g

17. **CONVICTIONS:** List any affiliate or owner who have one of the designated convictions identified in item #11. Provide the name of the applicant/affiliate, and conviction as an attachment

Do not forget the required signatures for completion of the application.