PROTECTIVE HEALTH SERVICES

Oklahoma State Department of Health
Protective Health Services
Medical Facilities
1000 NE 10th Street
Oklahoma City, OK 73117-1299
Telephone: (405) 271-6576
Email: PlanReview@health.ok.gov

Consultation Services Request for Long Term Care

INSTRUCTIONS

I. Read carefully and complete all portions of the form. **Please type.**

II. OSDH staff will work with the owner or representative to schedule a meeting as requested. Please be aware that meetings will be scheduled on a first come first serve basis and based on the availability of OSDH staff.

III. Consultations will be held at the OSDH. If a consultation is requested at another location please contact Medical Facilities at the phone number listed at the top. Additional fees may be charged in accordance with the State Travel Reimbursement Act 74 O.S. 85.451.

IV. Consultation Fee is $500 for each eight staff hours or major fraction thereof.

(a) The OSDH will review requests to determine if a formal consultation is required. If the issue is common staff knowledge and can be resolved through email or a phone call, then a request for consultation will be denied.

(b) Upon a receipt of confirmation letter regarding a request for consultation an applicant shall deposit with the OSDH the sum of $500. The OSDH will draw down on that $500 pursuant to the requirements found in Title 310 (*see below for specific sections*).

(c) Once the $500 has been expended the OSDH will notify the applicant if further consultation is required, upon this notification the applicant must deposit another $500 with the OSDH. This process will continue until the final decision on the application is made.

(d) Any money remaining in the account, at the request of the applicant, may be applied to any past, current or future fees owed by the applicant or may be returned to the applicant*.

V. <u>This form may be submitted by mail, in person or by email.</u>

a. **SUBMITTALS BY MAIL**: Submittals by mail should be sent to the following address:

Oklahoma State Department of Health
Protective Health Services
Medical Facilities Service
ATTN: Health Facilities Plan Review Division
1000 NE 10th Street
Oklahoma City, OK 73117-1299

b. **SUBMITTALS IN PERSON**: If submitting an application which is subject to a fee, the application must be accompanied by RECEIPT for the appropriate fee which is provided by the Financial Management Division when the payment is accepted. Please obtain this receipt from Financial Management, located on the 1st floor lobby of OSDH before

submitting any application.

c. **SUBMITTALS BY EMAIL**: Submit this form to the email address at the top of the page.

VI. **All REQUIRED FEES** must be submitted directly to the post office box listed below or submitted in person. Please do not submit fees to the Medical Facilities. Checks, money orders or bank drafts must be made payable to OKLAHOMA STATE DEPARTMENT OF HEALTH, must **clearly identify the project and the person requesting the courtesy inspection** with which the payment is associated and be mailed to:

Oklahoma State Department of Health
Protective Health Services
Medical Facilities—Plan Review Division
PO Box 268823
Oklahoma City, OK 73126-8816

***If a refund is requested an administrative cost will be charged to process the refund.**

TYPE OF FACILITY

☐ **Continuum of Care and Assisted Living – 310: 663-7-3(b)(5)**
☐ **Nursing and Specialized Facilities – 310:675-5-23(b)(5)**
☐ **Residential Care Homes – 310:680-5-9(b)(5)**

FACILITY INFORMATION

NAME OF FACILITY:

Tel. No.: _____ Fax No.: _____

Finding Address: _____
(Number & Street)

_____
(City) (State) (Zip)

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

OWNER/REPRESENTATIVE INFORMATION

Contact Name: _____

Contact Title: _____

Mailing Address: _____

Telephone: _____

Fax: _____

Email Address: _____

PRIMARY CONTACT INFORMATION

Contact Name: _____

Mailing Address: _____

Telephone: _____

Fax: _____

Email Address: _____

CONSULTATION INFORMATION

Preferred meeting dates: _____

Preferred meeting times: _____ ☐ a.m. ☐ p.m

Project attendees representing facility**:

**please list the names of the attendees and their job titles

PROJECT INFORMATION

Brief description of the project:

Specific project issue:

Specific rule, code, or guidelines section at issue:

Goals for this consultation: