

**OKLAHOMA STATE DEPARTMENT OF HEALTH
PROTECTIVE HEALTH SERVICES/HEALTH RESOURCES DEVELOPMENT SERVICE
1000 N.E. 10th Street
Oklahoma City, OK 73117-1299
(405) 271-6868 Fax. (405) 271-7360**

**CERTIFICATE OF NEED NOTICE
FOR PSYCHIATRIC OR CHEMICAL DEPENDENCY FACILITY OR UNIT
DECREASE OF BEDS OR CHANGE IN CONTINUUM OF CARE**

I. Name _____ of _____ Facility:

Street Address _____ City _____ State _____ Zip Code _____ Telephone _____

II. Contact _____ Person:

Mailing Address _____ City _____ State _____ Zip Code _____ Area Code/Telephone _____ Area Code/Fax Number _____

III. If Decrease: _____ beds ☐ Psychiatric ☐ Chemical Dependency ☐ Other _____ (Type _____ of Service)

How will beds be used after the above service is decreased or deleted?

IV. If change in continuum: # _____ Beds from _____ to _____
(current service) (proposed service)

NOTE: There must be no increase in number of beds.

V. Anticipated date of change:

VI. Authorization and Certification

A. Date project approved by applicant's policy body: _____, 19____.

B. I certify that the information and data in this notification is accurate to the best of my knowledge and belief by my signatures below.

Authorized signature for operator

Subscribed and sworn to before me on _____, 19____.

My Commission Expires: _____ Notary Public:

Note: File an original of this form at the address shown above. No filing fee is required.

OSDH USE ONLY: Dated rec'd: _____ Project # _____