OKLAHOMA State Department of Health

OKLAHOMA STATE DEPARTMENT OF HEALTH
PROTECTIVE HEALTH SERVICES/HEALTH RESOURCES DEVELOPMENT SERVICE
P.O. Box 268823
Oklahoma City, OK 73126-8823
Tel. (405) 426-8175 Fax (405) 900-7571

CERTIFICATE OF NEED APPLICATION FOR EXEMPTION FOR A LICENSED NURSING OR SPECIALIZED FACILITY MANAGEMENT AGREEMENT

I. Name and address of facility affected: _____

_____

_____

(Area Code) Telephone Number (Area Code) Fax Number

II. Name and address of contact person: _____

_____

_____

(Area Code) Telephone Number (Area Code) Fax Number

III. Current licensee of facility: _____

IV. Will the licensee for this facility change? [ ]Yes [ ]No If "yes," list name(s) of new licensee(s):

_____

V. Complete and attach Disclosure Statement, ODH Form 614 Certification of Need Disclosure Statement. This form may be obtained at http://www.health.state.ok.us/program/condiv/laws.html#c.

VI. Pursuant to OAC 310:4-1-13(f)(4), attach *copies of certificates of incorporation, bylaws, articles of organization, company operating agreements, certificates of limited partnership, or equivalent documents maintained pursuant to state or federal law, and any amendments of such documents. Instead of submitting a document that is not a public record previously filed with a local, state or federal government agency, the applicant may submit a sworn and notarized statement that includes all of the following information:*

(A) *Name and date of the document;*
(B) *Name and address of each person or entity that has current or proposed interests, responsibilities or participation in the ownership, operation or management of the facility or that otherwise makes or influences any decision relating to expenditures or operations affecting the facility, whether the person or entity is identified in the disclosed document by proper name or function;*
(C) *Description of the interest, responsibility, and/or nature of participation of each person or entity named pursuant to (f)(4)(B) of this section; and*
(D) *Location and address and telephone number of the place of business in Oklahoma wherein the applicant shall make the document(s) available for inspection by the Department, upon written request by the Department.*

VII. Attach a copy of the proposed management agreement that details the manager's responsibilities and duties.

VIII. Anticipated date of commencement of management agreement: _____

IX. This form must be accompanied by a $100.00 filing fee. Make checks payable to the Oklahoma State Department of Health.

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 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.

_____

Signature of Notary Public

Seal or Stamp:

My Commission Expires: _____/_____/

My Commission Number is:_____