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 TEN BED OR TEN PERCENT EXPANSION OF LICENSED CAPACITY

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. Number of beds to be added: _____ ☐ **by construction** ☐ **by conversion**
Note: The number of beds must be no more than ten percent of current beds, or no more than 10 beds, whichever is greater.

IV. Total capital cost: _____
Note: Total capital cost must be less than $1,000,000 including, but not limited to: site acquisition, construction, fixed and movable equipment, architectural designs and arrangements for financing.

V. Provide average occupancy rate for this facility: _____**%**
Note: The occupancy rate must be 93% or more during the twelve-month period preceding the filing of the application. **Attach documentation of computation method for occupancy rate. Attach copies of QOC–3 reports as submitted to the Oklahoma Health Care Authority for the twelve (12) months preceding the filing of this application.**

VI. Submit ODH Forms 953-B Disclosure Statement, 953-C Detail Attachment and 953-D Affirmation Attachment to provide complete disclosure of all persons and entities involved in and affected by the transfer.

VII. 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.

Seal or Stamp: _____
Signature of Notary Public

My Commission Expires: _____/_____/_____ My Commission Number is:_____