OKLAHOMA STATE DEPARTMENT OF HEALTH
PROTECTIVE HEALTH SERVICES/HEALTH RESOURCES DEVELOPMENT SERVICE
P.O. Box 268823
Oklahoma City, OK 73117-1299
Tel. 405-426-8175 Fax. 405-900-7571

CERTIFICATE OF NEED APPLICATION FOR FACILITY REPLACEMENT

I. Name of Facility: _____

Current Street Address City State Zip Code Telephone

Proposed Street Address City State Zip Code Telephone

II. Contact Person: _____

Mailing Address City State Zip Code Area Code/Telephone Area Code/FAX Number

III. Type of facility: [ ] Licensed nursing [ ] psychiatric [ ] chemical dependency

IV. Current number of licensed beds: Number of licensed beds in the new facility:

Note: The number of beds in the new facility must be no more than the current number of licensed beds.

V. Will the existing facility be used as a licensed nursing facility, psychiatric facility, or chemical dependency facility after the new facility is licensed?
[] Yes [] No

Describe how the existing facility will be used after the new facility is licensed:

VI. Long-term care facilities. Straight-line distance from current site to new site: _____ miles. Attach a map that shows the current and new locations, and demonstrates that the sites are no more than three miles apart. The map must include a mileage scale. This item does not apply to psychiatric or chemical dependency facilities, or to not-for-profit life-care communities.

VII. Total capital cost: $_____.

VIII. Disclosure Statement. Complete and attach the Disclosure Statement, ODH Form #614.

IX. Council Minutes. Attach copies of residents' council minutes and family council minutes, if any, and the facility's written response to the councils' requests or grievances, for the three (3) months prior to the date of application, for each of the applicant's current holdings in Oklahoma. Patient names or other identifying information regarding patients must be blacked out or removed from all minutes. Are all attached documents free of patient names and other identifying information for patients? ___Yes ___No

X. How many months after Department approval do you anticipate this project will be completed?

XI. Authorization and Certification

I certify that the foregoing information, and the information provided in the attachments to this application are 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: _____

Psychiatric and Chemical Dependency Facilities: File an original of this form, along with a filing fee based on three-quarters of one percent (.75%) of the capital cost of the project. (The capital cost is that amount listed in Item VII.) The minimum fee is $1,500, and the maximum fee is $10,000.
Long Term Care Facilities: File an original of this form, along with a filing fee equal to 1% of the capital cost of the project, with a maximum fee of $1,000.