Oklahoma State Department of Health
Protective Health Services, Medical Facilities
123 Robert S. Kerr, Suite 1702, Oklahoma City, OK 73102-6406
Phone: (405) 426-8620
Email: planreview@health.ok.gov

Project Documents Review Application

For questions about how to fill out the application or what a term may mean, reference the Instruction Guide below.

OSDH ASSIGNED PROJECT NUMBER: _____
(Will be assigned after the first fee submittal.)

PROPOSED OR ASSIGNED PROJECT NAME: (6 Words or Less): _____

SUBMITTAL REQUIREMENTS:

- Each submittal must include an application.
- Mail the first submittal with the fee attached for processing.
- If no fees are required, applications may be sent directly to the plan reviewer.
- In all cases, copy planreview@health.ok.gov on submissions for documentation and tracking.

SUBMITTALS RECOMENDED FOR FGI CODE REQUIRED PROJECTS:

- Functional Program.
- Space Program
- (Note: Not providing will increase likelihood of code comments and inspection issues)

UPLOADING PROCESS AND COMMUNICATION:

- Once your application is approved, you will receive a link to the OSDH Box account. Drag and drop the files into the designated folder. After the upload is complete, email planreview@health.ok.gov. Access will be removed once the upload is approved.
- The project will be placed in a queue for review in the order that the upload is approved. When the submittal process is complete, the review period begins according to the OSDH Plan Review process.
- To ensure a timely acknowledgment and/or reply to questions/concerns, refrain from emailing OSDH Plan Review team members directly. All emails must be sent to planreview@health.ok.gov and include the project number and "Attn: [Enter the Appropriate OSDH Contact Name Here]."
- Each submitted document must include the assigned OSDH project number.

FACILITY INFORMATION:

EXISTING LICENSED FACILITY	PROPOSED NEW OR RELOCATED FACILITY
LICENSED NAME (Parent facility if project affects satellite or hospital campus.)	PROPOSED LICENSED NAME
STREET ADDRESS & SUITE #	STREET ADDRESS & SUITE #
CITY, STATE & ZIP CODE	CITY, STATE & ZIP CODE
LICENSE #	CERTIFICATE OF NEED NUMBER (Skilled Nursing OAC 675 Only)

PROJECT REPRESENTATIVES:

FACILITIES/APPLICANT'S REPRESENTATIVE	ARCHITECT'S REPRESENTATIVE (If Applicable)
NAME	NAME
TITLE	TITLE
FIRM/FACILITY	FIRM
ADDRESS	ADDRESS
CITY, STATE & ZIP CODE	CITY, STATE & ZIP CODE
TELEPHONE	TELEPHONE
EMAIL ADDRESS	EMAIL ADDRESS

BED COUNT/NUMBER OF PARTICIPANTS OR RESIDENTS CHANGED:

FACILITY WITH LICENSED BEDS Applicable Yes ☐ No ☐		ADULT DAYCARE Applicable Yes ☐ No ☐		RESIDENTIAL CARE HOME Applicable Yes ☐ No ☐	
CURRENT LICENSED BED COUNT:	NUMBER	CURRENT NUMBER OF PARTICIPANTS:	NUMBER	CURRENT NUMBER OF RESIDENTS:	NUMBER
ADDITIONAL BEDS REQUESTED:	NUMBER	ADDITIONAL PARTICIPANTS REQUESTED:	NUMBER	ADDITIONAL RESIDENTS REQUESTED:	NUMBER
TOTAL:	NUMBER	TOTAL:	NUMBER	TOTAL:	NUMBER

PLAN REVIEW TYPES:

☐ **Revision**

Any submittal which occurs after approval of the submissions. Signed and sealed construction documents are required as well as a description of what was revised.

☐ **Full Review Process**

The OSDH Plan Review process typically involves two stages. Both stages require signed and sealed construction documents. Adult Day Care are exempt from this requirement.

1. Stage 1: Optional Preliminary Review – This early-stage review allows the preliminary documents and Project Narrative/Functional Program to receive feedback from the department. Approval of Stage 1 is not required. If an application was submitted, and a report was issued the responses may be incorporated into stage 2.
2. Stage 2: Required Final Review – Submit final construction documents and a Project Narrative/Functional Program for a detailed review. The department must approve these documents before beginning construction.

STAGE REQUESTED:

(Select one option for each category: Type, Stage, and Submittal.)

☐ Stage 1	☐ Stage 2	☐ NA
☐ Submittal 1	☐ Submittal 1	
☐ Submittal 2	☐ Submittal 2	

DOCUMENTATION FORMAT:

- The following are the document requirements for uploading:
  - File Naming Convention:
    - Project #-Project Name-Type of document-Stage-Submittal-Phase-Date
  - All Documents
    - Format: Documents must be in PDF
    - Text:
      - Copyable
      - Searchable
    - Page Quality:
      - Straight and clear pages
      - No streaks
      - Contrast: High
  - Plans
    - Complete Sets
    - Not combined with any other documents
    - Drawing Layers:
      - Flattened
    - Bookmarks: Include
      - sheet number and title
    - Page Orientation:
      - Landscape
    - Sheet Order:
      - Consistent with the cover sheet index
    - Security:
      - Documents must be unsecured to allow plan reviewers to add marks, notes and/or comments

PROJECT FACILITY TYPE:

MEDICAL FACILITIES	HUMAN RESOUCE DEVLOPMENT SERVICES (HRDS)
☐ Hospital (OAC:667)	☐ Skilled Nursing (OAC:675)
☐ Acute Care	☐ IID/ICF (OAC:675)
☐ Psychiatric Hospital	☐ Continuum Care and Assisted Living Facility (OAC:663)
☐ Rehabilitation Hospital	☐ Residential Care Home (OAC:680)
☐ Long Term Acute Care (LTAC)	☐ Adult Day Care (OAC:605)
☐ Hospital Outpatient Department (HOD)	
☐ Rural Emergency Hospital (REH)	
☐ Ambulatory Surgical Center (ASC) (OAC:615)	If other specify below:
☐ Hospice Inpatient Freestanding Facility (OAC:661)	

PROJECT/CONSTRUCTION SCOPE: (Licensed facilities only.)

☐ New Facility
☐ Existing Building with New License
☐ Building Addition to Existing Facility
☐ Renovations to Existing Facility
☐ Change of Use or Occupancy Classification in Licensed Facility
☐ Equipment Upgrade/Replacement
☐ Add Satellite to Hospital
☐ Relocation of Existing Facility/Department

FEE AMOUNT:

- Hospital, Ambulatory Surgical Center, and Inpatient Hospice
    - Project cost less than $10,000.00 $250.00
    - Project cost $10,000.00 to $50,000.00 $500.00
    - Project cost $50,001.00 to $250,000.00 $1,000.00
    - Project cost $250,001.00 to $1,000,000.00 $1,500.00
    - Project cost greater than $1,000,000.00 $2,000.00
- Skilled Nursing, Assisted Living, (ICF/IID-16), and Residential Care Homes
    - Two one-hundredths percent (0.02%) of the cost of design and construction of the project, with a minimum fee of $50.00 and a maximum fee of $1,000.00.
    - Example: Project cost is $1,000,000.00 X 0.0002 = $200.00
- Adult Day Care – No Fee

- Estimated Construction Cost: _____
- Document Review Fee:_____

FEE AND APPLICATION PROCESSING OPTIONS:

- **Mail to:** Oklahoma State Department of Health
  Financial Management – Receipting Unit
  PO Box 268823
  Oklahoma City, OK 73126-8823
- **Important Notes: In Person:**
  - Submit the fee to the cashier located in the OSDH Vital Records Office breezeway, immediately east of the Strata Tower. The cashier is available Monday through Friday from 2:00 PM to 4:00 PM, except on state holidays.
  - Applications will not be accepted by anyone other than the cashier.
- **Important Notes:**
  - Fees received without a submittal will not be accepted.
  - Plan Review/Medical Facilities staff will not accept any fees.
  - Fees must be paid by check or money order, payable to the Oklahoma State Department of Health.

COMMUNICATION AUTHORIZATION:

- The facility must provide below the organizations authorized to discuss this project. Communicate any changes in the list via e-mail to planreview@health.ok.gov.

ARCHITECTURAL RERESENTATIVE	CONSULTING ENGINEER RERESENTATIVE	FACILITY RERESENTATIVE
NAME	NAME	CONTACT NAME
DATE OF AUTHORIZATION	DATE OF AUTHORIZATION	DATE OF AUTHORIZATION
EXPIRATION OF AUTHORIZATION BY DATE OR EVENT (e.g., construction complete)	EXPIRATION OF AUTHORIZATION BY DATE OR EVENT (e.g., construction complete)	EXPIRATION OF AUTHORIZATION BY DATE OR EVENT (e.g., construction complete)
E-Mail Address	E-Mail Address	E-Mail Address