Oklahoma State Department of Health
Protective Health Services
Medical Facilities Service
Home Services Division
Phone: (405) 426-8470
Fax: (405) 900-7559

APPLICATION FOR A HOSPICE ALTERNATE ADMINISTRATIVE OFFICE (AAO)

1. APPLICATION TYPE & LICENSE FEE: *No such fee shall be refunded.*

License fee must accompany the application. Checks, money orders, or bank drafts must be made payable to ***OKLAHOMA STATE DEPARTMENT OF HEALTH*** and mailed with your completed application.

OKLAHOMA STATE DEPARTMENT OF HEALTH
FINANCIAL MANAGEMENT - RECEIPTING UNIT
PO BOX 268823
OKLAHOMA CITY, OK 73126-8823

________ $500.00 Initial Application Fee Proposed Effective Date: ________________

Note: *A Change of Information associated with an already established branch should be completed on Form ODH 924*

The undersigned hereby makes application for license to maintain a Hospice Alternate Administrative Office and is subject to the provisions of the Oklahoma Statutes and to the regulations adopted there under by the State Board of Health.

2. ENTITY: *(Name of organization responsible for the operation of the agency)* **License will be issued in this name.**

____ License#: ______________________
(Name)

D.B.A. ____
(Please attach PROOF the Entity and/or D.B.A. names are registered and match the Oklahoma Secretary of State website in accordance with Title 18 §22-1130 - 1140.)

3. PHYSICAL ADDRESS: ____
(Number & Street) (City) (County) (State) (Zip)

Mailing Address: ____
(Number & Street) (City) (County) (State) (Zip)

Phone: ______________________________ Fax: ______________________________

4. ADMINISTRATOR: ____
(Printed Name)

Email Address: ____

5. ALTERNATE ADMINISTRATIVE OFFICE INFORMATION:

Name: ______________________________________ (Required to be the same as the parent)

Location Address: ____
(Number & Street) (City) (County) (State) (Zip Code)

Phone: ______________________________ Fax: ______________________________

6a. INDICATE AVAILABLE SERVICES & HOW SERVICES ARE PROVIDED: As related to the Hospice, you must select one of the following for the corresponding service in the columns below: **Contract, Volunteer,** or **Employee**.

SERVICE	PARENT	AAO	SERVICE	PARENT	AAO
Nursing Services			Drugs & Biological		
Physical Therapy			Occupational Therapy		
Speech Therapy			Medical Social Services		
Hospice Aide			Home maker Services		
Dietary Counseling by Registered Dietician			Medical Supplies		
Counseling Services (Pastoral or other)			Short-term inpatient acute care		
Physician Services			Short- term respite care		
Bereavement Counseling			Durable Medical Equipment (DME)		

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6b. List locations for acute inpatient and respite care as an Attachment. Number response (6b)

6c. Provide a narrative explanation of how services are provided at the Hospice Alternate Administrative Office (AAO) related to the following items as an attachment. Number response (6c):

1. Coordination & continuity of care
2. Supervision of services
3. Patient care planning
4. Role & function of interdisciplinary group (IDG)
5. Informed consent
6. Clinical records
7. Compliance with accepted practices
8. Patient Right

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By my signature below, I certify that the foregoing is true and correct to the best of my knowledge and belief and also certify that I am not less than twenty-one (21) years of age; of reputable and responsible character; in sound physical and mental health; and have not been convicted of a felony, meaning a crime that would have a bearing on the operation of a Hospice Alternate Administrative Office. I attest to providing individual service plans, conducting criminal background checks and all other requirements of sections 310:661-2-1(f)(2).

SIGNATURE OF APPLICANT(S)

Signature: ______________________________ Typed Name: ______________________________

Title or Position: ______________________________ Date: ________________

Signature: ______________________________ Typed Name: ______________________________

Title or Position: ______________________________ Date: ________________

DETAILS FOR COMPLETING APPLICATION SECTIONS NUMBERED FOR LICENSE TO OPERATE A HOSPICE AAO

1. **APPLICATION TYPE & LICENSE FEE:** This application is to only be used to apply for the addition of an Alternate Administrative Office for an already existing Hospice Agency. Application may be made by the owner, administrative officer, managing agent or an authorized member of the governing body.

2. **ENTITY:** The Entity name is the name for which the license will be issued, if the entity has a doing business name this should be provided with a copy of the Secretary of State Trade Name Report. The AAO is required to operate under the same name as the licensee (parent location). 310:661-2-1(f)(2)(C)

3. **PHYSICAL ADDRESS:** Physical address is the actual location of the business (please note an agency cannot be located in a home). Please note correspondence will be mailed to the mailing address associated with the parent location. Include the telephone number, after hour number, and fax number for the entity. The AAO must be located within a geographical area with a radius of no more than 50 miles from the parent location of the hospice. 310:661-2-1(f)(2)(A)

4. **ADMINISTRATOR:** List the Administrator that will be in charge of the agency and list their email address. The AAO must be operated under the same administration and governing body as an extension site for services of the main hospice. 310:661-2-1(f)(2)(C)

5. **BRANCH OFFICE(S):** Provide the location (address, city, zip code, and phone number) information, for the actual AAO site associated with this application.

6. **AAO QUESTIONNAIRE:** a. Provide answers to the Service Chart in the body of the application. 6b & 6c. Complete responses to the questionnaire in detail as an attachment. Number all responses in accordance with questions 1-8. Number Attachment.

Do not forget the required signatures for completion of the application.