OKLAHOMA State Department of Health

Oklahoma State Department of Health
Health Facilities Systems
PO Box 268823, Oklahoma City, OK 73126-8823
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DISCLOSURE STATEMENT

Owner, Lessee, Manager for a Long-Term Care Facility

http://hfs.health.ok.gov

This Disclosure Statement is being submitted for the following type of review:

☐ Initial License ☐ Amendment to previous filing ☐ Renewal License ☐ Suspended License

1. Facility Identification **Facility ID #** _____

Facility Name (d.b.a. name):_____

2. Owner(s)/Lessor(s) of Building, Land and Equipment Information

A. Name of Owner(s)/Lessor(s): _____

_____
Street City State Zip

Telephone Number:_____Fax Number:_____

B. If this Entity is a Government Entity check the type that applies:

____ Public Trust Authority_____County ____ City_____State

C. Complete *Detail Attachment to the Disclosure Statement* (ODH Form 953-C) for the Owner(s)/Lessor(s), as an attachment to **2C**.

3. Lessee Information
If the lease includes sub-leases, complete for all parties.

Is the facility leased?____Yes ___No If "yes", continue. If "no," skip to No. 4.

A. Name of Lessee:_____

_____
Street City State Zip

Telephone Number:_____Fax Number:_____ _____

B. If this Entity is a Government Entity check the type that applies:

☐ Public Trust Authority_____County ____ City_____State

C. Complete ODH Form 953-C for the Lessee, as an attachment to **3C**.

4. Manager/Supervisor Information
Does the licensee contract with a manager or supervisor (as defined in OAC 310:675-1-2) to perform management or administrative services. This requires certificate of need approval or exemption approval.
Yes___No. If "yes," continue. If "no," skip to No. 5.

A. Name of Manager/Supervisor:_____

_____

Street City State Zip

Telephone Number:_____Fax Number: _____

B. If this Entity is a Government Entity check the type that applies:

___ Public Trust Authority____County ____ City____State

C. Complete ODH Form 953-C for the Manager/Supervisor as attachment **4C**.

5. Affirmation

Submit a copy of the *Affirmation Attachment to the Disclosure Statement* (ODH Form 953-D) for each person who holds an interest or position as described in the instructions of ODH Form 953-C.

6. Have there been changes in the following? (Check all that apply and provide effective date.)

_____Owner/lessor Effective date of change: _____ Email Address:

_____Lessee Effective date of change: _____

_____Manager/supervisor Effective date of change: _____

Notice to Applicant

The Nursing Home Care Act requires the applicant to provide, under oath, true and complete information regarding the facility and the applicant. Willfully filing false, incomplete or misleading information is a misdemeanor subject to prosecution by the District Attorney or the Attorney General. In addition, any person willfully providing false, incomplete or misleading information is subject to an administrative penalty of up to $3,000 per day and suspension, non-renewal or revocation of the facility's license.

I certify the information provided in this application and attachments 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.

Seal or Stamp

_____

Signature of Notary Public

My Commission Expires:_____/_____/_____

My Commission Number is:_____