



**STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH LICENSURE AND REGULATION
OFFICE OF HEALTH CARE FACILITIES
665 MAINSTREAM DRIVE, SECOND FLOOR
NASHVILLE, TENNESSEE 37243**

**HOSPITALS
PROCEDURES FOR APPLYING FOR LICENSURE OF A NEW FACILITY**

1. You must first apply for a Certificate of Need (CON) from the Health Services and Development Agency prior applying for licensure of this type of facility. Once you obtain a CON you will need to submit a notarized application along with the appropriate licensure fee to the address at the top of the application.
2. Obtain architectural plans signed and sealed by an architect or Tennessee licensed engineer. Submit the plans to the Plans Review Section of Health Care Facilities. Once you receive approval of the architectural plans you may begin building the facility. If it is an existing building you will need to make any renovations that the plans reviewer has indicated. Approximately thirty (30) to forty-five (45) days prior to completion of the construction/renovations you will need to send a letter to the Regional Office in your area to request a survey of the facility. The Regional Office will notify you to schedule the survey. Be certain that you have given yourself plenty of time to have the building completed and to have your policies and procedures in order. If you are not ready on the date of survey, it will most likely be thirty (30) days or more before the survey can be rescheduled.
3. Once the survey has been completed the surveyor will tell you if a recommendation is going to be made to license your facility. The surveyor will forward the appropriate forms to the Regional Office for the Regional Director's signature. The forms will then be forwarded to the Central Office Licensure Division in Nashville.
4. Licensure staff will then process the forms and send an initial approval letter to you. The application will then be presented to the Board for Licensing Health Care Facilities at the next regularly scheduled board meeting for ratification. If the Board ratifies the application the license will then be ordered from the computer center. You should receive the license in seven (7) to ten (10) days.
5. If the Board does not ratify the initial approval of your application, a letter will be mailed to you providing an explanation and specific instructions as to any actions you may take to have the decision reviewed, at which time this authorization shall cease to be effective.

All applicable laws, rules, policies, and guidelines affecting your practice are available for viewing at <http://tn.gov/health/topic/hcf-professionals>. Please check this website periodically for updates.



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**HOSPITALS
APPLICATION FOR INITIAL LICENSURE**

All applicable laws, rules, policies, and guidelines affecting your practice are available for viewing at <http://tn.gov/health/topic/hcf-professionals>. Please check this website periodically for updates.

Name of the Facility/Agency _____

Location of the Facility:

Street _____ City _____

County _____ State _____ Zip _____

Phone Number (____) _____ Fax Number (____) _____

Twenty-four (24) Hour Emergency Phone Number (____) _____

E-Mail Address _____

Total Bed Capacity _____

Administrator Information:

Administrator _____

Have you (Administrator) ever been convicted of a crime involving injury or harm to person(s), financial or business management (e.g., assault, battery, robbery, embezzlement or fraud)? Yes _____ No _____

If yes, what charge(s)? _____

Location of Conviction _____ Date _____
(City) (County) (State)

Mailing address if different from the Facility location address:

Name _____

Street _____

City _____ State _____ Zip _____

Ownership of Building:

Name _____ Phone Number (____) _____

Street _____

City _____ State _____ Zip _____

FEE SCHEDULE: (FEES ARE NON-REFUNDABLE)

| <u>Bed Capacity</u> | <u>Fee</u> | <u>Bed Capacity</u> | <u>Fee</u> |
|---------------------|------------|---------------------|------------|
| Less than 25 | \$ 800 | 100 thru 124 | \$1,600 |
| 25 thru 49 | \$1,000 | 125 thru 149 | \$1,800 |
| 50 thru 74 | \$1,200 | 150 thru 174 | \$2,000 |
| 75 thru 99 | \$1,400 | 175 thru 199 | \$2,200 |

Facilities with 200 beds or more shall pay a flat rate of \$2400 + \$200 for each additional 25 beds or fraction thereof (i.e., 200-224 pays \$2,400; 225-249 pays \$2,600).

1. Check classification of institution for which application is made:

General Hospital Orthopedic Pediatric EENT Rehab Chronic Disease

2. List the number of beds in each category, if applicable, for which acute care beds are utilized.

Swing beds Psychiatric Beds Alcohol and Drug Abuse Beds NICU Rehab

3. Check type of services provided:

- | | | |
|---|--|--|
| a. <input type="checkbox"/> Surgical | f. <input type="checkbox"/> Chronic | k. <input type="checkbox"/> ICU/CCU/NICU |
| b. <input type="checkbox"/> Obstetrics | g. <input type="checkbox"/> Orthopedics | l. <input type="checkbox"/> Burn |
| c. <input type="checkbox"/> Well Baby Nursery | h. <input type="checkbox"/> Pediatrics | m. <input type="checkbox"/> Trauma |
| d. <input type="checkbox"/> Psychiatric | i. <input type="checkbox"/> Rehabilitation | n. <input type="checkbox"/> Cancer Treatment |
| e. <input type="checkbox"/> Alcohol and Drug | j. <input type="checkbox"/> Emergency | o. <input type="checkbox"/> Outpatient |

4. If trauma was indicated above, what is the trauma designation? _____

5. If pediatrics was indicated above, what is the pediatric emergency designation? _____

OWNERSHIP OF BUSINESS:

1. a. Check the type of Legal Entity:

Individual Partnership Corporation Limited Liability Company
 Church Related Government/County Other

b. Check One: For Profit Non-profit

c. Legal Entity checked in 1.a:

Name _____ Phone Number (____) _____
Address _____

d. List name(s) and address(es) of individual owners, partners, directors of the corporation, or head of the governmental entity:

| | | |
|------|--------|------------------|
| Name | Street | City, State, Zip |
| Name | Street | City, State, Zip |

(If additional space is needed, please use a separate sheet)

2. a. Is your facility/organization accredited by a **federally approved** accrediting body (i.e., JCAHO, CARF, etc)?

Yes No Expiration Date _____

b. Is your facility/organization deemed by a **federally approved** accrediting body (i.e., JCAHO, CARF, etc)?

Yes No Expiration Date _____

3. If you have a parent company please provide the following information:
 Name _____ Phone Number (____) _____
 Address _____
4. a. Are any owners of the disclosing entity or also owners of other health care facilities in Tennessee and/or other states? Yes ____ No ____
 b. If yes, list names and addresses of all such facilities:

5. a. Do you have a contract with a management firm to operate this facility? Yes ____ No ____
 If yes, specify dates: From _____ To _____
 b. If yes, specify name of firm: _____
 Phone Number (____) _____

 Street _____ City, State, Zip _____
6. a. Have any owners of the disclosing entity ever been denied a license, had a license suspended or revoke, had a suspension of admissions or paid any civil monitory penalties for a health care facility in Tennessee or in any other state? Yes ____ No ____
 b. If yes, where? _____ When? _____
 c. For what reason? _____

VERIFICATION BY NOTARY PUBLIC:

Signee for application certifies that he or she is of responsible character and able to comply with the minimum standards and regulations established by Tennessee pertaining to the type of facility or agency for which application for licensure is made and with the rules promulgated under Tennessee Code Annotated (TCA) § 68-11-201.

Signee also certifies that a policy has been implemented to inform all employees of their obligation under TCA § 71-6-103 to report incidents of abuse or neglect.

 Applicant Signature Title or Position Date

STATE OF TENNESSEE

County of _____

The above named applicant (print name) _____, being by me duly sworn on his/her oath, deposes and says that he/she has read the forgoing application and knows the contents thereof: that the statements concerning the above named facility or agency, therein contained, are correct and true to his/her own knowledge.

Subscribed to and sworn to on this _____ day of _____
 Month Year

Notary Public: _____

My commission expires: _____