



**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**

**PROFESSIONAL SUPPORT SERVICES
PROCEDURES FOR APPLYING FOR LICENSURE OF A NEW FACILITY**

1. Prior to submitting a licensure application and fee to Health Care Facilities ensure that an initial approval letter is obtained from the Department of Intellectual and Developmental Disabilities (DIDD). Submit a notarized application along with the appropriate licensure fee and a copy of the initial approval letter from DIDD to the address at the top of the application.
2. Approximately thirty (30) to forty-five (45) days prior to your being ready to open your facility 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 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 Section in Nashville.
4. Licensure staff will then process the forms and send an initial approval letter to you contingent on you executing a final provider agreement with DIDD/TennCare. The application will then be presented to the Board for Licensing Health Care Facilities (HCF) at the next regularly scheduled board meeting for ratification **ONLY** after HCF has received a copy of the final executed provider agreement. 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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665 MAINSTREAM DRIVE, SECOND FLOOR
NASHVILLE, TENNESSEE 37243-0508
(615) 741-7221**

**PROFESSIONAL SUPPORT SERVICES
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 _____

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)

\$270 - If one of the following apply, please place check beside the one that applies and submit proof:

- 1. You are currently licensed by the Department of Mental Health and Developmental Disabilities
- 2. You are a therapist who pays a fee to be licensed by Title 63, Chapter 13 or 17 and own a home care organization
- 3. You are a home care organization owned and controlled by another home care organization and pay an annual licensure fee of \$1,080

\$1,080 - If you are a home care organization authorized to provide professional support services only

- 1. Does your facility have a current provider agreement contract with DIDD to provide Professional Support Services?

(Please refer to #4 note of the instruction sheet). Yes No

- 2. Geographic area served by Agency: (check appropriate region or regions).

East Middle West

- 3. Check type of services provided:

- a. Skilled Nursing
- b. Physical Therapy
- c. Occupational Therapy
- d. Speech Therapy

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

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 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:

c. _____

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 (_____) _____

Address: _____
Name 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 monetary 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: _____