DIVISION OF HEALTH LICENSURE AND REGULATION
OFFICE OF HEALTH CARE FACILITIES
665 MAINSTREAM DRIVE, SECOND FLOOR
NASHVILLE, TENNESSEE 37243
(615) 741-7221

HOME HEALTH AGENCY RENEWAL APPLICATION

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

Name of the Facility/Agency ______________________________

Facility License Number ______________________________

Location of the Facility:

Street ______________________________ City ______________

County ______________ State ______________ Zip ______________

Phone Number (____) ______________ Fax Number (____) ______________

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

Email 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 ______________

Geographic area served by Agency: (list county or counties) *If additional space is needed, please use a separate page.*

____

____

____

Check type of services provided:

a.	Skilled Nursing	_____	f.	Home Health Aide Services	_____
b.	Physical Therapy	_____	g.	Medical Supplies and Appliances	_____
c.	Occupational Therapy	_____	h.	Homemaker Services	_____
d.	Speech Therapy	_____	i.	Other (please specify)	_____
e.	Medical Social Services	_____			

Do you provide services to a pediatric population? Yes _____ No _____

If yes, what counties ____

Is your agency a provider in the EEOICPA federal program? Yes _____ No _____

If yes, what counties? ____

Number of Branch Office(s): __________

Address/Phone Number of each branch office location. ***(If you need additional space, please attach separate sheet)***

____

____

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 (   ) ______________________

   Street ____

   City ______________________________ State ______________________ Zip __________________

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

   ____
   Name Address City, State, Zip

   ____
   Name Address 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)? **Provide proof of current accreditation.**

   Yes _____ No _____ Expiration Date ____

3. a. Is this facility chain affiliated? Yes _____ No _____

   b. If yes, list name, address and phone number of the parent company:

   Name ______________________________Phone Number (____)______________________

   Street ____

   City ______________________________State _______________ Zip _______________

4. a. If a corporation, is there a holding company/parent corporation? Yes _____ No _____

   b. If yes, list the name, address and phone number of the holding company/parent corporation:

   Name ______________________________Phone Number (____)______________________

   Street ____

   City ______________________________State _______________Zip _______________

5. 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:

   ____

   ____

   ____

6. 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: ____

   Street ___________________________________Phone Number (_____)_______________

   City ______________________________ State _______________ Zip _______________

7. 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? ____

FEES: REFER TO THE FEE RENEWAL INVOICE ENCLOSED WITH THIS APPLICATION. FEES ARE NON-REFUNDABLE.

VERIFICATION BY APPLICANT:

Signee for application verifies 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 verifies 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