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 bottom 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.

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)

Bed Capacity	Fee	Bed Capacity	Fee
Less than 25	$1,040	100 thru 124	$2,080
25 thru 49	$1,300	125 thru 149	$2,340
50 thru 74	$1,560	150 thru 174	$2,600
75 thru 99	$1,820	175 thru 199	$2,860

Facilities with 200 beds or more shall pay a flat rate of $2,860 + $200 for each additional 25 beds or fraction thereof (i.e., 200-224 pays $3,060; 225-249 pays $3,260).

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	_____ Surgical	f.	_____ Chronic	k.	_____ ICU/CCU/NICU
b.	_____ Obstetrics	g.	_____ Orthopedics	l.	_____ Burn
c.	_____ Well Baby Nursery	h.	_____ Pediatrics	m.	_____ Trauma
d.	_____ Psychiatric	i.	_____ Rehabilitation	n.	_____ Cancer Treatment
e.	_____ Alcohol and Drug	j.	_____ Emergency	o.	_____ Outpatient

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

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

6. a. Do you have a ST-Elevation Myocardial Infarction (STEMI) designation? Yes _____ No _____

   b. If yes, provide proof of designation, and please check one:

   _____ Receiving Center _____ Referring Center _____ N/A

7. a. Do you have a Stroke related designation? Yes _____ No _____

   b. If yes, provide proof of designation, and please check one:

   ___ Comprehensive Stroke Center ___ Primary Stroke Center ___ Acute Stroke-Ready Hospital ___ Other ___ N/A

8. **Provide proof of the ability to meet the financial needs of the facility.**

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 including but not limited to JCAHO, CARF, etc.?

Yes _____ No _____ Expiration Date _____

b. Is your facility/organization deemed by a **federally approved** accrediting body including but not limited to 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: _____