

## TRAUMATIC BRAIN INJURY (TBI) RESIDENTIAL HOME APPLICATION FOR RENEWAL LICENSURE

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

Name of the TBI Residen	tial Home Facility			
Location of the TBI R	Residential Home Facili	<u>ty</u> :		
Street			City	
County		State		Zip
Phone Number ()		Fax Number (	)	
Twenty-four (24) Hour E	mergency Phone Number <u>(</u>	)		
E-Mail Address				
Mailing address (if di	fferent from the TRI R	esidential Home Facility l	ocation address)	•
City		State		Zip
Number of Residents TBI Residential Hom		residents by blood/marriage a	re related to the pro	wider?
Name of Provider				
Residential Manager(	<u>(s)</u> :			
Manager		Substitute Caregiver (if applica	able)	
management (e	.g., assault, battery, robber	ed of a crime involving injury of y, embezzlement or fraud)?	Yes No	
Location of Conviction	(City)	(County)	Date (State)	·
	-	er, substitute caregivers and oth		
c. Has a policy Yes N		their obligations to report inci-		eglect been implemented?

Division of Health Licensure and Regulations, Office of Health Care Facilities, 665 Mainstream Drive, Second Floor, Nashville, TN 37228-1254

## **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(s) of individual owners, partners, directors of the corporation, or head of the governmental entite (If additional space is needed, please use a separate sheet.)			
		NameAddressCity, State, Zip			
		Name       Address       City, State, Zip			
2.		If you have a parent company please provide the following information:			
		Name Phone Number ( )			
		Address			
3.	a. stat	Are any owners of the disclosing entity also owners of other health care facilities in Tennessee and/or other es? Yes No			
	b.	If yes, list names and addresses of all such facilities: (If additional space is needed, please use a separate sheet.)			
4.	a.	Have any owners of the disclosing entity ever been denied a license, had a license suspended or revoked, had a suspension of admissions, paid any civil monitory penalties or other disciplinary actions for a health care facility in Tennessee or in any other state? Yes No			
	b.	If yes, where? When?			
	c.	For what reason?			
		rately attach proof the adult care home's financial ability to maintain sufficient financial resources to support the operating he TBI residential home.			

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

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## **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

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