ADULT CARE HOME
APPLICATION FOR RENEWAL LICENSURE

All applicable laws, rules, policies, and guidelines affecting your practice are available for viewing at https://www.tn.gov/hfc/division-of-licensure-and-regulation/hfc-licensure/licensure-applications.html. Please check this website periodically for updates.

Name of the Adult Care Home Facility____

Location of the Facility:

Street____City ____________________________

County___________________________State_______________________Zip ________________

Phone Number (_____)________________________Fax Number (_____)____________________________

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

E-Mail Address ____

Mailing address (if different from the Facility location address):

Name____

Street____

City______________________________State________________________Zip _________________

Number of Residents____________How many residents by blood/marriage are related to the provider ____________

Adult Care Home Provider:

Name ofProvider____

Residential Manager(s):

Manager_________________________________Substitute Caregiver (if applicable)________________________

a. Have you (Manager) 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)

b. To what extent will the resident manager, substitute caregivers and other staff be used in the facility?

____

____

c. Has a policy of informing employees of their obligations to report incidents of abuse or neglect been implemented? Yes___________No_____

RENEWAL FEE SCHEDULE: (FEES ARE NON-REFUNDABLE) - $1404.00

SPECIALIZED SERVICE(S) (check appropriate service)

________Ventilator Dependent ________Traumatic Brain Injury

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 entity:

   ____
   Name Address City, State, Zip

   ____
   Name Address City, State, Zip

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

   e. If a government/county owned facility, does the administrator have authority to act on behalf of the government/county as it relates to the operation of this facility? Yes ______ No ______

   f. If no to e., who has said authority? ____

2. 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 you have a parent company, please provide the following information:

   Name____Phone Number (_____)________________________

   Address ____

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 ____________

2. 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:

   ____

   ____

3. 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 ____________

4. 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 states? Yes_____ No_____

   b. If yes, where? ____________________ When? ____________________

   c. For what reason? ____

5. Separately attach proof the adult care home's financial ability to maintain sufficient financial resources to support the operating costs of the adult care home.

6. Separately attach a Comprehensive Business Plan for the first two years of operation.

7. 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? ____

8. List any unsatisfied judgments ____

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