HOME MEDICAL EQUIPMENT
RENEWAL APPLICATION

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 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 (_____)_____

E-mail Address _____

Does your facility have a physical location in the state of Tennessee? Yes_____ No_____

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_____

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)***

_____

_____

_____

Number of Branch Office(s): _____

Address/Phone Number of each branch office location: (***If additional space is needed, attach a 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)

   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. a. Is your facility/organization accredited by a **federally approved** accrediting body but not limited to JCAHO, CARF, etc.? Yes_____No_____Expiration Date _____
   Provide proof of current accreditation.

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? Yes_____ No _____

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

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 states? 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.

□ By checking this box, you acknowledge that you will ensure access to a secure online portal is available to Health Facilities Commission surveyors in order to conduct all necessary and required surveys related to licensure.

Applicant Signature	Title or Position	Date