PROFESSIONAL SUPPORT SERVICES

PROCEDURES FOR APPLYING FOR LICENSURE OF A NEW FACILITY

1. Prior to submitting a licensure application and fee to Health Care Facilities ensure that an initial approval letter is obtained from the Department of Intellectual and Developmental Disabilities (DIDD). Submit a notarized application along with the appropriate licensure fee and a copy of the initial approval letter from DIDD to the address at the top of the application.

2. Approximately thirty (30) to forty-five (45) days prior to your being ready to open your facility 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 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 Section in Nashville.

4. Licensure staff will then process the forms and send an initial approval letter to you contingent on you executing a final provider agreement with DIDD/TennCare. The application will then be presented to the Board for Licensing Health Care Facilities (HCF) at the next regularly scheduled board meeting for ratification **ONLY** after HCF has received a copy of the final executed provider agreement. 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 https://www.tn.gov/hfc/division-of-licensure-and-regulation/hfc-licensure/licensure-applications.html.. Please check this website periodically for updates.

PROFESSIONAL SUPPORT SERVICES APPLICATION FOR INITIAL 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 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 ____

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)

$351 - If one of the following apply, please place check beside the one that applies and submit proof:

_______ 1. You are currently licensed by the Department of Mental Health and Developmental Disabilities

_______ 2. You are a therapist who pays a fee to be licensed by Title 63, Chapter 13 or 17 and own a home care organization

_______ 3. You are a home care organization owned and controlled by another home care organization and pay an annual licensure fee of $1,404

$1,404 - If you are a home care organization authorized to provide professional support services only

1. Does your facility have a current provider agreement contract with DIDD to provide Professional Support Services? (**Please refer to #4 note of the instruction sheet**). Yes_____ No_____

2. Geographic area served by Agency: (check appropriate region or regions).

____________________ East ________________Middle _________________West

3. Check type of services provided:
   a. Skilled Nursing ________ c. Occupational Therapy ________
   b. Physical Therapy ________ d. Speech Therapy __________

Site Codes:

1. Number of sites codes: ________

Code Number, address and phone of each site: ***(If additional space is needed, please use a separate page)***

____

____

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

____
Name Street 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 including but not limited to JCAHO, CARF, etc.? **Provide proof of accreditation.**

Yes ______ No_____ Expiration Date____

3. Is this facility chain affiliated? Yes______ No_____

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

Name________________________________Phone Number (_____)____________________

Address ____

5. 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______________

6. 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: ***(If additional space is needed, please use a separate sheet)***

   ____

   ____

7. 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 (_____)____

   Address:____

   Name Street City, State, Zip

8. 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: ___________________________________