STATE OF TENNESSEE
DEPARTMENT OF HEALTH
BUREAU OF HEALTH LICENSURE AND REGULATION
DIVISION OF HEALTH CARE FACILITIES
227 FRENCH LAND, SUITE 501
HERITAGE PLACE METROCENTER
NASHVILLE, TENNESSEE 37243

ADULT CARE HOME PROCEDURES FOR APPLYING FOR INITIAL LICENSURE

1. Submit a notarized application along with the appropriate licensure fee; financial statement and a comprehensive business plan to the address at the top of the application.

2. Obtain architectural plans signed and sealed by an architect or Tennessee licensed engineer. Submit 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 the building is an existing single family home to be licensed for five (5) or fewer beds you are not required to submit architectural plans that are signed and sealed by an architect or Tennessee licensed engineer. You will only be required to submit one set of schematic drawings. For an existing building, you will need to make any renovations that the plans reviewer has indicated.

3. 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.

4. 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.

5. 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.

6. 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 www.state.tn.us/health. Please check this website periodically for updates.

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NASHVILLE, TENNESSEE 37243
(615) 741-7221

ADULT CARE HOME
APPLICATION FOR INITIAL LICENSURE

All applicable laws, rules, policies, and guidelines affecting your practice are available for viewing at www.state.tn.us/health. 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 of Provider____

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___________

SPECIALIZED SERVICE(s) (Check appropriate service)

________ Ventilator Dependent ________ Traumatic Brain Injury

FEE SCHEDULE: (FEES ARE NON-REFUNDABLE) - $1080.00

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)

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

Name ____ Phone Number (_____)________________________

Address ____

3. 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:

____

____

4. 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.

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

6. 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? ____

7. List any unsatisfied judgments ____

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: ______________________________