



**STATE OF TENNESSEE  
DEPARTMENT OF HEALTH  
DIVISION OF HEALTH LICENSURE AND REGULATION  
OFFICE OF HEALTH CARE FACILITIES  
665 MAINSTREAM DRIVE, SECOND FLOOR  
NASHVILLE, TENNESSEE 37243**

**ASSISTED CARE LIVING FACILITIES (ACLF)  
PROCEDURES FOR APPLYING FOR LICENSURE OF A NEW FACILITY**

1. Submit a notarized application along with the appropriate licensure fee; financial statement prepared by a certified public accountant; copy of local business license (if applicable to the locality); and a copy of any and all documents demonstrating the legal status of the business organization that owns the ACLF to the address at the top of the application.
2. Obtain architectural plans signed and sealed by an architect or Tennessee licensed engineer. Submit the 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 it is an existing building you will need to make any renovations that the plans reviewer has indicated. 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.
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 Division in Nashville.
4. 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.
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 <http://tn.gov/health/topic/hcf-professionals>. Please check this website periodically for updates.*



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(615) 741-7221**

**ASSISTED CARE LIVING FACILITIES  
APPLICATION FOR INITIAL LICENSURE**

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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 \_\_\_\_\_

Total Bed Capacity \_\_\_\_\_

Does the facility have a secured unit? Yes \_\_\_ No \_\_\_ Number of Secured Beds \_\_\_\_\_

Does the facility have Adult Day Care services? Yes \_\_\_ No \_\_\_ If yes, how many beds \_\_\_\_\_

Does the facility provide Pet Therapy? Yes \_\_\_ No \_\_\_

**Administrator Information:**

Administrator \_\_\_\_\_ Certificate number or Nursing Home Administrator Number \_\_\_\_\_

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)**

<u>Bed Capacity</u>	<u>Fee</u>	<u>Bed Capacity</u>	<u>Fee</u>
Less than 25	\$ 800	100 thru 124	\$1,600
25 thru 49	\$1,000	125 thru 149	\$1,800
50 thru 74	\$1,200	150 thru 174	\$2,000
75 thru 99	\$1,400	175 thru 199	\$2,200

*Facilities with 200 beds or more shall pay a flat rate of \$2400 + \$200 for each additional 25 beds or fraction thereof (i.e., 200-224 pays \$2,400; 225-249 pays \$2,600).*

**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)*

2. a. Is your facility/organization accredited by a **federally approved** accrediting body (i.e., JCAHO, CARF, etc)?

Yes \_\_\_\_\_ No \_\_\_\_\_ Expiration Date \_\_\_\_\_

b. Is your facility/organization deemed by a **federally approved** accrediting body? (i.e., JCAHO, CARF, ETC)?

Yes \_\_\_\_\_ No \_\_\_\_\_ Expiration Date \_\_\_\_\_

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

Name \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_  
Address \_\_\_\_\_

4. 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:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. 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, please specify name of firm: \_\_\_\_\_  
 Phone Number ( \_\_\_\_\_ ) \_\_\_\_\_  
 \_\_\_\_\_  
 Street \_\_\_\_\_ City, State, Zip \_\_\_\_\_
6. 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: \_\_\_\_\_