HOME HEALTH AGENCY
PROCEDURES FOR APPLYING FOR LICENSURE OF A NEW FACILITY

1. You must first apply for a Certificate of Need (CON) from the Health Services and Developmental Agency prior to applying for licensure of this type of facility. Once you obtain a CON you will need to submit a notarized application along with the appropriate licensure fee 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 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.
HOME HEALTH AGENCY
APPLICATION FOR INITIAL LICENSURE

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.

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) $1,080
1. Check type:  Hospital Based _____  Nursing Home Based _____  Free Standing _____

2. Check type:  Licensed only Agency _____  Licensed/Medicaid Certified _____

3. Geographic area served by Agency: (list county or counties) If additional space is needed, please use a separate page.

4. Check type of services provided:
   a. Skilled Nursing _____  f. Home Health Aid Services _____
   b. Physical Therapy _____  g. Medical Supplies and Appliances _____
   c. Occupational Therapy _____  h. Homemaker Services _____
   d. Speech Therapy _____  i. Other (please specify) _____
   e. Medical Social Services _____

5. Number of branch offices: ________
   Address of each branch office: (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

      (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., ICAHO, 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 _____
   If yes, where? ____________________________________________ When? ______________
   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: ___________________________

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