HOSPICE SERVICES
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 Development 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.
**HOSPICE SERVICES**

**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](http://tn.gov/health/topic/hcf-professionals). Please check this website periodically for updates.

Name of the Facility/Agency ________________________________________________________

**Location of the Facility:**

<table>
<thead>
<tr>
<th>Street</th>
<th>City</th>
<th>County</th>
<th>State</th>
<th>Zip</th>
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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 ____________________________________________________________

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<tr>
<th>City</th>
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<th>State</th>
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**Mailing address if different from the Facility location address:**

Name ______________________________________________________________

<table>
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<tr>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
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**Ownership of Building:**

Name ______________________________________________________________

<table>
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<tr>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
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**FEE SCHEDULE: (FEES ARE NON-REFUNDABLE) $1,404**

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Division of Health Licensure and Regulations, Office of Health Care Facilities, 665 Mainstream Drive, Second Floor, Nashville, TN 37228-1254

PH-3638 (REV 7/19) RDA-1165
1. **Geographic area served by Agency:** (list of county or counties) *If additional space is needed, please use a separate page.*

2. Number of branch offices: __________

   Address of each branch office: (If additional space is needed, please use a separate page)

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<th>Name</th>
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3. **Provide proof of the ability to meet the financial needs of the facility.**

   **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 but not limited to JCAHO, CARF, etc.? _____ Yes _____ No _____ Expiration Date __________________________

   b. Is your facility/organization deemed by a **federally approved** accrediting body but not limited to 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 or 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, 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

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: ____________________________