HOME MEDICAL EQUIPMENT
PROCEDURES FOR APPLYING FOR LICENSURE OF A NEW FACILITY

1. 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 MEDICAL EQUIPMENT
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 ( ) __________________________
Business Customer Service Phone Number with twenty-four (24) hour access/seven (7) days a week ( ) __________
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 ____________________________________________________________
(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 _________________

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

PH-3639 (Rev 7/19) RDA-1165
1. Are you a provider providing manufactured or distributing company-branded Insulin Infusion Pumps and related supplies? Yes____ No____ (If so, the following are requirements, which must be met).
   a. Do you have an employee presence within the state of Tennessee? Yes____ No____
      (Please describe the nature of the employee’s physical presence in the state)__________________________
   b. Provide Joint Commission Accreditation (JCAHO). (Please provide JCAHO letter and complete report in accordance with T.C.A. TCA 68-11-226(e))

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

3. Number of branch offices: __________
   Address of each branch office: (If additional space is needed, please use a separate page)

4. 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 (____) __________________
      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, 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 ____________

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

PH-3639 (Rev 7/19)  RDA-1165
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: _________________________________