TRAUMATIC BRAIN INJURY (TBI) RESIDENTIAL HOMES
CHANGE OF OWNERSHIP PROCEDURES

1. Submit a notarized application along with the appropriate fee and a letter of intent 60 days prior to the anticipated Change of Ownership (CHOW) to the address at the bottom of the application. The letter of intent should include the name of the facility, the name of the seller\lessee of the facility, acknowledgment by the seller\lessee authorizing the sale or lease of the facility's operations and the projected date of the CHOW. Submission of a CHOW application indicates the acquisition and sale\lease of the entire facility operations including the associated license.

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2. A letter will be sent acknowledging the receipt of the application**,** fee and notice of intent. Once the change of ownership has occurred and you receive the closing documents, you will need to send a copy of the bill of sale or the documents, including lease of operations agreements that indicate that you are now the owner or lessee of the facility to:

Office of Health Care Facilities
665 Mainstream Drive, Second Floor
Nashville, Tennessee 37243

3. This office will notify the regional office in your area to request their recommendation for the intended CHOW. The regional office will review the facility file to determine if a survey has been conducted within the previous fifteen (15) months with no outstanding deficiencies, and secondly to determine survey performance history including both scheduled and complaint surveys**.** If a survey has been conducted in the last fifteen (15) months and the facility's survey history including complaint surveys is satisfactory, a form recommending approval of the CHOW will be submitted to the central office in Nashville. If a survey has not been conducted within the previous fifteen (15) months or any complaint(s) rising to the level of a detriment to the health, safety, and welfare of the residents of the facility has been reported then; an on-site survey of the facility will be conducted. The regional office **will not** recommend approval of the CHOW, until an on-site survey is conducted with substantial compliance and/or deficiencies from either this on-site survey or a previous survey are corrected. The applicant/buyer will be notified by the regional office, if an onsite survey is necessary.

4. Once the recommendation **and** the signed closing document(s) with the effective date of the CHOW are received in the central office, a letter will be forwarded to you initially approving the CHOW. The effective date of the CHOW will be the date of the closing document(s) is signed or the date the regional office recommends approval of the CHOW, if occurring after the closing date. 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 approval of the CHOW the license number listed above will become your permanent license number and a letter will be forwarded to you within three working days notifying you of the Board's final decision. You should receive your wall license within seven (7) to ten (10) business days thereafter.

5. If the Board does not ratify the initial approval of the CHOW, that initial authorization shall cease to be effective. 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.

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.

TRAUMATIC BRAIN INJURY (TBI) RESIDENTIAL HOME APPLICATION FOR CHANGE OF OWNERSHIP

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 TBI Residential Home Facility_____

Location of the TBI Residential Home 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? _____

TBI Residential 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_____

FEE SCHEDULE: (FEES ARE NON-REFUNDABLE)

Bed Capacity	Fee	Bed Capacity	Fee
Less than 25	$1,040	100 thru 124	$2,080
25 thru 49	$1,300	125 thru 149	$2,340
50 thru 74	$1,560	150 thru 174	$2,600
75 thru 99	$1,820	175 thru 199	$2,860

Facilities with 200 beds or more shall pay a flat rate of $2,860 + $200 for each additional 25 beds or fraction thereof (i.e., 200-224 pays $3,060; 225-249, $3,260).

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: *(If additional space is needed, please use a separate sheet.)*

_____

Name Address City, State, Zip

_____

Name Address City, State, Zip

2. a. Is this CHOW a lease of operations in accordance with Rule 1200-08-37? Yes_____No_____

b. If yes, please provide the lessor's information below:

Name_____ Phone Number (___) _____

Address_____

3. a. Is your facility/organization accredited by a **federally approved** accrediting body including but not limited to

JCAHO, CARF, etc.? Yes _____ No _____ Expiration Date _____

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

JCAHO, CARF, etc.? Yes _____ No _____ Expiration Date _____

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

Name _____ Phone Number (____) _____

Address _____

5. 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: *(If additional space is needed, please use a separate sheet.)*

_____

_____

6. For any item in (7) a-h below, please identify, explain and provide documentation of the item(s) noted if response is "Yes". Have either the licensed entity for any of the other health care facilities in Tennessee and/or other states on the list in question (5.b.) above, OR the management firm listed in question (6.) above; been subjected to any of the following within the last (5) years:

a. **Licensure**

i) denied a license ? Yes____No_____

ii) had a license suspended or revoked by any state licensure agency? Yes____No_____

iii) been subject to a final order or judgment in a state licensure action? Yes____No_____

b. **Convictions**

i) convicted of a criminal offense related to that person's involvement in any program under any state or Federal health care program (including Medicare, Medicaid, and Tricare)? Yes____No_____

c. **Exclusion**

i) excluded from participation in Federal health care programs (Medicare, Medicaid, CHIP, or Tricare) in the past? Yes____No_____

(Note: "Excluded" is defined as a provider or entity has been told by the Department of Health and Human Services, Office of the Inspector General (HHS-OIG) that they may no longer be a provider for any federally funded healthcare program).

d. **Termination/Suspension**

i) suspended or terminated from participation in Medicare or Medicaid/TennCare programs? Yes____No_____

(Note: This would include involuntary termination of a nursing facility or skilled nursing facility by the Centers for Medicare and Medicaid Services (CMS) or state Medicaid agency).

e. **Fraud and Abuse**

i) paid through settlement, or civil or criminal fines, any monies to the federal government or any state as a result of any administrative or judicial proceeding based on allegations of fraud or abuse involving claims related to the provision of health care items and services? Yes____No_____

f. **Corporate Integrity Agreement**

i) Is presently an entity covered by and subject the terms of a corporate integrity agreement? Yes____No_____

(Note: If yes, provide a copy of CIA)

g. **Bankruptcy**

i) filed bankruptcy under any provision of the United States Bankruptcy Code? Yes____No_____

h. **Civil Monetary Penalty (CMP)**

i) paid to the Centers for Medicare and Medicaid Services or any state Medicaid agency a civil money penalty equal to or greater than $250,000.00 as a result of an enforcement action during a survey? Yes____No_____

7. Separately attach proof the adult care home's financial ability to maintain sufficient financial resources to support the operating costs of the TBI residential home.

8. Separately attach a Comprehensive Business Plan for the first two (2) years of operation.

9. Separately attach a list of any unsatisfied judgments (if applicable).

10. Separately attach a list of any past and/or present litigation against the applicant (if applicable).

11. Separately attach a list of any unpaid local, state and federal taxes (if applicable).

12. Separately provide notification of any bankruptcy filings (if applicable).

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: _____