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 Facilities Commission. 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 Unit in Nashville.

4. Licensure staff will then process the forms and send an initial approval letter to you. **Residents cannot be admitted to your facility until you have received an initial approval letter from the Central Office Licensure Unit in Nashville.** The application will then be presented to the Commission at the next regularly scheduled Commission meeting for ratification. If the Commission ratifies the application the license will then be ordered from the computer center. You should receive the license in seven (7) to ten (10) business days.

5. If the Commission 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.

6. Notice regarding Assisted Care Living Facilities (ACLFs) seeking Medicaid reimbursement: ACLFs in Tennessee **must** be licensed by the Health Facilities Commission. In addition, ACLFs that want to serve Medicaid recipients **must** be compliant with the federal Home and Community Based Services (HCBS) Settings Rule as a requirement of eligibility to become a TennCare provider and receive Medicaid reimbursement. ACLFs not in compliance with the HCBS Settings Rule **will not** be able to be credentialed to participate as a TennCare provider and receive Medicaid reimbursement until such ACLFs come into compliance with the HCBS Settings Rule.

All applicable laws, rules, policies, and guidelines affecting your practice are available for viewing at https://www.tn.gov/hfc/division-of-licensure-and-regulation/hfc-licensure/licensure-applications.html. Please check this website periodically for updates.

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_____Telephone Number (____) Street_____

Street_____

City_____State_____Zip_____

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 pays $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(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.)

e. If a government/county owned facility, does the administrator have authority to act on behalf of the government/county as it relates to the operation of this facility? Yes _____ No _____

f. If no to e., who has said authority? _____

2. Is your facility/organization accredited by a **federally approved** accrediting body but not limited to JCAHO, CARF, etc.? **Provide proof of accreditation.**

Yes_____ No_____ Expiration Date_____

3. Is this facility chain affiliated? Yes_____ No_____

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

Name_____Telephone Number (_____)_____

Address _____

5. a. If a corporation, is there a holding company? Yes_____ No_____

b. If yes, list the name, address and phone number of the holding company:

Name_____ Phone Number (_____)_____

Street_____

City_____State_____Zip_____

6. 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:

_____

_____

7. 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

8. For any item in (8) 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 (6.b.) above, OR the management firm listed in question (7.) 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_____

a. 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)

b. Bankruptcy

i) Filed bankruptcy under any provision of the United States Bankruptcy Code? Yes_____ No_____

c. 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_____

Failure to provide true and correct copies of any documents related to the items list in 8(a-h) listed above may be grounds for referral of the application for special consideration, and/or may be grounds for disciplines.

If the applicant answered "Yes" to any of the questions (a)-(h) above, please provide copies of any documentation associated with the event and/or sanction. The documentation should provide the Health Facilities Commission with sufficient information regarding the nature of the event and/or sanction, the current status of the issue, as well as details regarding what corrective action shave been implemented (as applicable).

9. Demonstrate the ability to meet the financial obligations of the ACLF with a financial statement prepared by a certified public accountant.

VERIFICATION BY NOTARY PUBLIC

Signee for application certifies that he/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	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: _____