ADULT CARE HOME
APPLICATION FOR RENEWAL LICENSURE

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.

Name of the Adult Care Home Facility_____

Location of the 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 _____

Adult Care 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____

RENEWAL FEE SCHEDULE: (FEES ARE NON-REFUNDABLE) - $1404.00

SPECIALIZED SERVICE(S) (check appropriate service)

_____Ventilator Dependent _____Traumatic Brain Injury

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:

Name	Address	City, State, Zip
Name	Address	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 (i.e., JCAHO, CARF, etc)? **Provide proof of current accreditation.**

Yes_____ No_____ Expiration Date _____

3. a. Is this facility chain affiliated? Yes_____ No_____

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

Name_____Phone Number (_____)_____

Address _____

4. a. If a corporation, is there a holding company/parent corporation? Yes_____ No_____

b. If yes, list the name, address and phone number of the holding company/parent corporation.

Name_____Phone Number (_____)_____

Street_____

City_____State_____Zip _____

2. 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:

   _____

   _____

3. 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: _____

   Street_____Phone Number (_____)_____

   City_____State_____Zip _____

4. 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 states? Yes_____ No_____

   b. If yes, where?_____When? _____

   c. For what reason? _____

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

6. Separately attach a Comprehensive Business Plan for the first two years of operation.

7. a. Have any owners of the disclosing entity ever been denied a license, had a license suspended or revoked, had a suspension of admissions, paid any civil monitory penalties or other disciplinary actions for a health care facility in Tennessee or in any other state? Yes_____ No _____

   b. If yes, where?_____When? _____

   c. For what reason? _____

8. List any unsatisfied judgments _____

VERIFICATION BY APPLICANT:

Signee for application verifies 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 verifies 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