HOME HEALTH SERVICES PROCEDURES FOR APPLYING FOR LICENSURE OF A NEW FACILITY

1. You must first apply for a Certificate of Need (CON) from the Health Facilities Commission prior to applying for licensure of this type of facility. If your agency will provide only pediatric services and/or services in the EEOICPA federal program, a CON is not required prior to applying for licensure, but you will be required to obtain accreditation within two (2) years of initiation of services as identified in T.C.A. §68-11-1607(r)(1) & (s)(3). Once you obtain a CON you will need to submit a notarized application along with the appropriate licensure fee to the address at the bottom 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 Unit 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 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.

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.

HOME HEALTH SERVICES
APPLICATION FOR INITIAL 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 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 _____

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, 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 _____ Phone Number (____) _____

Street _____

City _____ State _____ Zip _____

1. Check type: Hospital Based _____ Nursing Home Based_____ Free Standing_____

2. Check type: Licensed only Agency _____ Licensed/Medicaid Certified _____

3. Check type of services provided:

a. Skilled Nursing	_____	f. Home Health Aid Services	_____
b. Physical Therapy	_____	g. Medical Supplies and Appliances	_____
c. Occupational Therapy	_____	h. Homemaker Services	_____
d. Speech Therapy	_____	i. Other (please specify)	_____
e. Medical Social Services	_____		

4. Do you have a Certificate of Need (CON)? Yes_____ No_____

   If yes, what is the geographic area served by the Agency: (list county or counties) If additional space is needed, please use a separate page.

   _____

   _____

5. Do you provide services to a pediatric population? Yes _____ No _____

   If yes, what counties? _____

6. Is your agency a provider in the EEOICPA federal program? Yes _____ No _____

   If yes, what counties? _____

7. 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

   (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. a. Is your facility/organization accredited by a **federally approved** accrediting body including 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 _____ Phone 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. <u>Licensure</u>

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. <u>Convictions</u>

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. <u>Exclusion</u>

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_____

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).

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: _____

FEE SCHEDULE: (FEES ARE NON-REFUNDABLE) $1,404