HOSPICE SERVICES
RENEWAL APPLICATION

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 _____

Facility License Number _____

Location of the Facility:

Street_____City _____

County _____ State_____ Zip_____

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, 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_____Phone Number (_____)_____

Street_____

City_____State_____Zip _____

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

_____

_____

_____

Number of Branch Office(s): _____

Address/Phone Number of each branch office location. (***If you need additional space, please attach separate sheet***)

_____

_____

_____

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 (_____)_____

   Street_____

   City_____State_____Zip _____

   d. List name(s) and address(es) 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. a. 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. a. Is this facility chain affiliated? Yes_____No _____

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

Name_____Phone Number (_____)_____

Street_____

City_____State_____Zip _____

4. a. If a corporation, is there a holding/parent company? Yes_____No _____

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

Name_____Phone Number (_____)_____

Street_____

City_____State_____Zip _____

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:

_____

_____

_____

6. 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 _____

7. 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? _____

FEES: REFER TO THE FEE RENEWAL INVOICE ENCLOSED WITH THIS APPLICATION. FEES ARE NON-REFUNDABLE.

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