HOSPITALS 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 applying for licensure of this type of facility. 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. 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. 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) 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.

HOSPITALS
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 _____

Total Bed Capacity _____

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 _____

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).

1. Check classification of institution for which application is made:

   General Hospital_____Orthopedic_____Pediatric_____EENT_____Rehab_____Chronic Disease_____

2. List the number of beds in each category, if applicable, for which acute care beds are utilized

   Swing beds_____ Psychiatric Beds_____ Alcohol and Drug Abuse Beds _____NICU _____Rehab_____

3. a. Do you have a ST-Elevation Myocardial Infarction (STEMI) designation? Yes _____ No _____

   b. If yes, provide proof of designation, and please check one:

   Receiving Center _____Referring Center _____ N/A _____

4. a. Do you have a Stroke related designation? Yes _____ No _____

   b. If yes, provide proof of designation, and please check one:

   Comprehensive Stroke Center _____ Primary Stroke Center _____ Acute Stroke-Ready Hospital____
   Other _____ N/A_____

5. Pediatric Emergency Care Facility Designation (please check one):
   Basic _____CRPC _____General _____ Primary _____

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. Is your facility/organization accredited by a **federally approved** accrediting body including but not limited to JCAHO, CARF, etc.? **If so, 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 or 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 _____

   b. If yes, specify the dates: From:_____To:_____

   If yes, specify the name of the firm:_____

   Street_____

   City_____State_____Zip_____

   Phone Number (_____)_____

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_____

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 me on this_____day of _____
Month Year

Notary Public: _____

My commission expires: _____