# NURSING HOME
# PROCEDURES FOR APPLYING FOR LICENSURE OF A NEW FACILITY

1. You must first apply for a Certificate of Need (CON) from the Health Services and Development Agency 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 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 Care Facilities. 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 Division 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 Division in Nashville.** The application will then be presented to the Board for Licensing Health Care Facilities at the next regularly scheduled board meeting for ratification. If the Board 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 Board 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.*

# NURSING HOMES
# APPLICATION FOR INITIAL LICENSURE

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Name of the Facility/Agency _____

**Location of the Facility:**

Street _____

City _____ County _____ State _____ Zip _____

Telephone Number (_____) _____ Fax Number (_____) _____

Twenty-four (24) Hour Emergency Phone Number (_____) _____

E-Mail Address _____

Total Bed Capacity _____

Does the facility have a Secure Unit? Yes _____ No _____ Number of Secured Beds _____

Does the facility have an Alzheimer's Unit? Yes _____ No _____ Number of Alzheimer Beds _____

Does the facility have a ventilator unit? Yes _____ No _____ Number of Ventilators Beds _____

Does the facility have Adult Day Care services? Yes _____ No _____ If yes, how many beds _____

Does the facility provide Outpatient Therapy Yes _____ No _____

Pet Therapy? Yes _____ No _____

Does this facility offer dialysis services? Yes _____ No _____

If yes, is it a den concept? Yes _____ No _____ Number of stations _____

If yes, is it bedside dialysis? Yes _____ No _____ Number of Beds _____

**Administrator Information:**

Administrator _____ Nursing Home Administrator License 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)? _____

City _____ County _____ State _____ Date _____

**Mailing address if different from the Facility location address:**

Name_____

Street_____

City_____ State_____ Zip_____

**Ownership of Building:**

Name_____ Phone (_____)_____

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, $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 (_____)_____

Address _____

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

_____

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 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 (_____)_____

   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 _____

   If yes, specify dates: From_____To _____

   b. If yes, specify name of firm: _____

   Phone (_____)_____

   Address_____

8. 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 state? Yes _____ No _____

   b. If yes, where?_____When? _____

   c. For what reason?_____

## 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 this_____day of _____
(Month) (Year)

Notary Public: _____

My commission expires: _____