



NURSING HOME 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 _____

Phone Number (____) _____ Fax Number (____) _____

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

E-Mail Address _____

Total Number of Licensed Beds _____ Does this facility have a secured unit? Yes ___ No ___

Number of Secured Beds _____

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

Does this facility have a ventilator unit? Yes ___ No ___ Number of Ventilator Beds _____

Does this facility provide Adult Day Care services? Yes ___ No ___ If yes, how many beds _____

Does this 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)? _____

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 _____

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 (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 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 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 _____

5. a. Are any owners of the disclosing entity also owners of other health care facilities in Tennessee and/or other states?
Yes _____ No _____

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 state? 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