PROFESSIONAL SUPPORT SERVICES

PROCEDURES FOR APPLYING FOR LICENSURE OF A NEW FACILITY

1. Prior to submitting a licensure application and fee to Health Facilities Commission (HFC) ensure that an initial approval letter is obtained from the Department of Disability and Aging. Submit a notarized application along with the appropriate licensure fee and a copy of the initial approval letter from the Department of Disability and Aging to the address at the top 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 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 contingent on you executing a final provider agreement with the Department of Disability and Aging/TennCare. The application will then be presented to the Commission at the next regularly scheduled Commission meeting for ratification **ONLY** after HFC has received a copy of the final executed provider agreement. 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.

PROFESSIONAL SUPPORT SERVICES
APPLICATION FOR INITIAL LICENSURE

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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 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)

$351 - If one of the following apply, please place check beside the one that applies and submit proof:

_____ 1. You are currently licensed by the Department of Mental Health and Developmental Disabilities

_____ 2. You are a therapist who pays a fee to be licensed by Title 63, Chapter 13 or 17 and own a home care organization

_____ 3. You are a home care organization owned and controlled by another home care organization and pay an annual licensure fee of $1,404

$1,404 - If you are a home care organization authorized to provide professional support services only

1. Does your facility have a current provider agreement contract with DIDD to provide Professional Support Services? (**Please refer to #4 note of the instruction sheet**). Yes_____ No_____

2. Geographic area served by Agency: (check appropriate region or regions).

_____ East _____Middle _____West

3. Check type of services provided:
   a. Skilled Nursing _____ c. Occupational Therapy _____
   b. Physical Therapy _____ d. Speech Therapy _____

Site Codes:

1. Number of sites codes: _____

Code Number, address and phone of each site: ***(If additional space is needed, please use a separate page)***

_____

_____

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

_____

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: ***(If additional space is needed, please use a separate sheet)***

_____

_____

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 Number (_____)_____

Address:_____

Name 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: _____