PROFESSIONAL SUPPORT 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 _____

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 _____

1. Does your facility have a current provider agreement with DIDD to provide Professional Support Services?

   Yes_____ No _____

   (Please note before renewal can be finalized a copy of your current provider agreement MUST be attached).

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

   _____ East _____Middle _____West

Check type of services provided:

a. Skilled Nursing_____ c. Occupational Therapy _____

b. Physical Therapy_____ d. Speech Therapy _____

Site Codes:

1. Number of site codes: _____

Code number, address and phone number 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 (_____)_____

   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
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 _____

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