



## TRAUMATIC BRAIN INJURY (TBI) RESIDENTIAL HOME APPLICATION FOR RENEWAL 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 TBI Residential Home Facility \_\_\_\_\_

**Location of the TBI Residential Home Facility:**

Street \_\_\_\_\_ City \_\_\_\_\_

County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Number (\_\_\_\_) \_\_\_\_\_ Fax Number (\_\_\_\_) \_\_\_\_\_

Twenty-four (24) Hour Emergency Phone Number (\_\_\_\_) \_\_\_\_\_

E-Mail Address \_\_\_\_\_

**Mailing address (if different from the TBI Residential Home Facility location address):**

Name \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Number of Residents \_\_\_\_\_ How many residents by blood/marriage are related to the provider? \_\_\_\_\_

**TBI Residential Home Provider:**

Name of Provider \_\_\_\_\_

**Residential Manager(s):**

Manager \_\_\_\_\_ Substitute Caregiver (if applicable) \_\_\_\_\_

a. Have you (Manager) 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)

b. To what extent will the resident manager, substitute caregivers and other staff be used in the facility?

\_\_\_\_\_  
\_\_\_\_\_

c. Has a policy of informing employees of their obligations to report incidents of abuse or neglect been implemented?  
Yes \_\_\_\_\_ No \_\_\_\_\_

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

Name	Address	City, State, Zip
_____	_____	_____
_____	_____	_____

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 ( \_\_\_\_\_ ) \_\_\_\_\_  
Address \_\_\_\_\_

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

---

---

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 revoked, had a suspension of admissions, paid any civil monetary penalties or other disciplinary actions for a health care facility in Tennessee or in any other state? Yes \_\_\_\_ No \_\_\_\_

b. If yes, where? \_\_\_\_\_ When? \_\_\_\_\_

c. For what reason? \_\_\_\_\_

8. Separately attach proof the traumatic brain injury residential home's financial ability to maintain sufficient financial resources to support the operating costs of the TBI residential home.

**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 \_\_\_\_\_