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(s) 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
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 monitory 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