Date Rec'd _____
Fee Paid _____
Check/MO# _____
Receipt # _____

Tennessee Department of Human Services
APPLICATION FOR A LICENSE
TO OPERATE AN ADULT DAY SERVICES AGENCY

Instructions: This application must be completed in full. **Attach additional paper as needed.** Do not leave any blanks. If you are unsure how to answer a question mark "?", you may contact: _____. If the question does not apply to you mark "N/A". For any item requiring additional space, please attach additional sheets.

(please type or print)

Identifying Information

_____
Name of Adult Day Services Agency

_____ _____
FEIN Number Telephone Number

_____
Agency Address City Zip Code

_____
Agency Mailing Address City Zip Code

_____
Name of Applicant Telephone Number

_____
Applicant Address City Zip Code

_____
Driver's License Number & State Social Security Number Applicant or Agency Email Address (if any)

Business Organization

For all organization types marked with an ***** you must attach copies of all filings with the office of the Secretary of State.

Full Legal Name and d/b/a Name of Business:

_____

Legal Organization: **(choose one only)**

- ☐ Sole Proprietor
- ☐ Partnership
- ☐ Limited Liability Partnership (L.L.P.)*****
- ☐ Public Agency (all or part of the agency is owned or operated by a government entity)

List full name and address of sponsoring government agency:

_____

_____

List full name of contact person for sponsoring government agency:

_____

List full name of contact person for parent corporation:

_____

Business Organization, continued:

☐ Corporation (choose one of the following)

☐ Public Non-Profit

List full name and address of sponsoring government agency:

_____

List full name of contact person of sponsoring government agency:

_____

☐ Private Non-Profit*****

☐ For Profit*****

☐ Limited Liability Corporation*****

☐ Other***** (describe business organization)

_____

_____

Has the type of legal organization changed since issuance of the last license (for re-application only)?

Yes ___ No ___

If yes, state the type of the previous legal organization:

_____

List All Owners (Attach Lists of Additional Owners):

Full Name: _____

Social Security Number: _____

Address:

_____

_____

Work Phone: _____ Home Phone: _____ Other Phone: _____

List Names, Locations (city/state) and Dates of Services for every adult day services agency the individual has owned, operated, been employed by, or volunteered for:

_____

_____

List All Members of the Oversight Authority (e.g., Governing Board):

Name: _____ Position Title: _____

Address: _____

Work Phone: _____

List Names, Locations (city/state) and Dates of Services for every adult day services agency the individual has owned, operated, been employed by, or volunteered for:

_____

_____

Attach list of additional members.

Initial Application Information

Complete this section only if an initial application of Director

Name of Director: _____

Education: ___ GED ___ High School Diploma ___ College (___ Associates ___ Bachelors ___ Masters ___ Other)

Name of School (Attach copy of Diploma / Certificate / Transcript)

Address City Zip Code

Specialized Education related to adult day services

Experience in working in social services, health and/or related field: (List most recent experience first, attach additional sheets of paper if necessary)

Employer Contact Person Telephone Number

Address Dates Worked

Employer Contact Person Telephone Number

Address Dates Worked

Employer Contact Person Telephone Number

Address Dates Worked

Employer Contact Person Telephone Number

Address Dates Worked

(Attach copy of your Resume - If available)

References: (List 3 who are non-relatives with complete address and daytime telephone numbers)

Name Address Telephone Number (include area code)

Program and Services

Who is your target population? _____

Please describe your program IN DETAIL:

_____

Is your agency accredited? [ ] Yes [ ] No

If yes, accrediting organization.

_____

A. Number and type of meals and snacks to be served:

_____

1. Do you participate in the Child and Adult Care Food Program? [ ] Yes [ ] No

2. Do you [ ] prepare and serve meals,
   [ ] have meals catered, or
   [ ] participants required to bring a sack lunch

Program and Services, continued

3. Please describe the arrangements you have made for food planning/preparation (e.g. food preparation area, cook, consultation with nutritionist) or in food service (e.g. where participants eat, staff support)?

_____
_____
_____

Please provide a comprehensive list of services offered to participants and families: (i.e.: skilled nursing, physical or occupation therapy, transportation, case management, transportation, off-site activities)

_____

List additional fees charged and amount of each, for example assessment fee, registration fee, transportation fee, therapy fee.

Service	Fee	Service	Fee	Service	Fee

B. If agency provides transportation, describe transportation plans, procedures and the vehicles utilized in the transportation. Include all vehicle license plate numbers:

_____
_____
_____
_____

Do you contract with a 3rd party to provide any programs or services? Example: Transportation; Physical, Occupational, Art or Music Therapy

If yes, please describe:

_____
_____

You must attach a legible copy of all contracts for adult day services programs and services.

List your rates and rate schedule; fulltime, part-time, daily, weekly, monthly, etc.

Rate	Frequency	Rate	Frequency	Rate	Frequency
Rate	Frequency	Rate	Frequency	Rate	Frequency

Days of Operation: [ ] M [ ] T [ ] W [ ] Th [ ] F [ ] Sat [ ] Sun

Holidays: _____

Hours of Operation: _____a.m. - _____p.m.

Do you accept part time enrollment/ [ ] Yes [ ] No

List all funding sources. [ ] Private Pay [ ] Medicaid Waiver [ ] SSBG [ ] Long Term Care Insurance [ ] Other

C. Admission requirements and enrollment procedures;

_____
_____

Provision for emergency medical care;

_____
_____

D. Insurance:

Vehicle Liability Insurance: Name of Company

_____

Program and Services, continued

Policy Number _____ Expiration Date _____

E. Have there been any changes in the following areas in the past year?
1. Has Agency changed admission policy [ ] Yes [ ] No
2. Has your agency made any changes in family involvement/education activities:
   [ ] Yes [ ] No If yes, please explain.

_____

_____

3. Hours of operation [ ] Yes [ ] No
4. Room usage [ ] Yes [ ] No
5. Schedule [ ] Yes [ ] No
6. Program philosophy or policies [ ] Yes [ ] No
7. Program activities [ ] Yes [ ] No
8. Other (explain):

   _____

   If any item(s) 1-8 marked yes, explain changes made.

   _____
   _____
   _____

Staff Records and Qualifications

Staff Name & Position	Date Started Work	Date Fingerprint Sample Submitted	Training Hours This Licensing Year	Years of Experience	Highest Level of Education	Date of Physical	Date of Staff Orientation	Date of CPR	Date of First Aid	Date of Personnel Evaluation	Date of Work History Verification	Date References Checked

Staff Records and Qualifications (continued)

Staff Name & Position	Date Started Work	Date Fingerprint Sample Submitted	Training Hours This Licensing Year	Years of Experience	Highest Level of Education	Date of Physical	Date of Staff Orientation	Date of CPR	Date of First Aid	Date of Personnel Evaluation	Date of Work History Verification	Date References Checked

Staffing Pattern

Use the chart below to describe how the program is staffed. For each hour of the day indicate the number of participants enrolled in the group, the staff members assigned to the group, and the hours worked by each staff members. A group is the number of participants assigned to a staff member or team of staff members occupying an individual room or well-defined space within a larger room. If your program is not organized into self-contained rooms but employs an open space organizational structure and/or allows for a free flow of participants between spaces, please attach clear information about the arrangement of the environment (a floor plan) and how the participants are grouped within it. Clarify how the staffing criteria (adult:participant ratio) are met in this environment. See examples below. Make additional copies as needed for all groups.

EXAMPLES

AM	NUMBER OF DIRECT CARE STAFF AND PARTICIPANTS EACH HOUR												PM
6:00	7:00	8:00	9:00	10:00	11:00	12:00	1:00	2:00	3:00	4:00	5:00	6:00	7:00
0	1:2	1:8	2:10	2:10	2:10	2:10	2:10	2:9	2:9	1:5	1:5	1:2	

Hours of each staff member
Julie (7:30 – 3:30)
M. Smith (8:00 – 12:00)
Marty (12:00 – 6:30)

STAFFING PATTERN

AM	NUMBER OF PARTICIPANTS ENROLLED EACH HOUR												PM
6:00	7:00	8:00	9:00	10:00	11:00	12:00	1:00	2:00	3:00	4:00	5:00	6:00	7:00

Hours of each staff member

Declarations

I affirm that I am the owner or the authorized representative of the owner of the adult day services agency and the information provided is accurate, correct and complete to the best of my knowledge.

I have read and understand the rules by which my agency is to operate, and it is my intent to maintain compliance with them.

I understand that providing false or misleading information may result in the denial of the application or revocation of the current license, and may additionally constitute a Class A misdemeanor, pursuant to the provisions of T.C.A. § 71-3-505(c)(1)(3) and (4).

I understand that *any* change in ownership or in the organization of the business ***automatically terminates*** the adult day services license. I understand that I am required to notify the Department *before* changing ownership or changing the organization of the adult day services agency.

"I understand that by my signature, I am authorizing the Department of Human Services to verify the information supplied in this application. I agree to abide by the licensing standards of the Department of Human Services and the licensing laws (T.C.A. § 71-2-401 et seq.). I understand that the appropriate fee must be submitted to the Tennessee Department of Human Services when applying for a license to operate an adult day services facility, and is **non-refundable**.

Application Fee

I am applying for an adult day services license to operate the following type agency and agree to submit the indicated fee by cashier's check or money order payable to the **Treasurer, State of Tennessee (Adult Day Services license)** Please mail your application and fee to:

	Adult Day Services Center			**Adult Day Services Center**			**Adult Day Services Center**	
	5 – 19 Participants			20 - 100 participants			More than 100 participants	
	Annual Fee	$125		Annual Fee	$200		Annual Fee	$400

(Please sign below):

Print Name of Individual Completing Form:

_____ Title: _____

Signature of Director: _____ Date: _____

Print Name of Owner or Authorized Representative (signature of owner or authorized representative required):

_____ Title: _____

Signature of Owner or
Authorized Representative: _____ Date: _____