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|  | **Tennessee Department of Human Services**  **Application for a License to Operate an Adult Day Services Agency** |

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| --- | --- | --- |
| **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. | Date Rc’d |  |
| Fee Paid |  |
| Check/MO# |  |
| Receipt # |  |

**(Please type or print)**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Identifying Information** | | | | | | | | |
|  | | | -     - | | |  | -   - | |
| Name of Adult Day Services Agency | | | FEIN Number | | | Extension | Phone Number | |
|  | | | |  | | |  |  |
| Agency Street Address | | | | City | | | State | ZIP |
|  | | | |  | | |  |  |
| Agency Mailing Address | | | | City | | | State | ZIP |
|  | | | | | | | -   - | |
| Name of Applicant | | | | | | | Phone Number | |
|  | | | |  | | |  |  |
| Applicant Address | | | | City | | | State | ZIP |
|  |  | -    - | | |  | | | |
| Driver’s License Number | State of DL | Social Security Number | | | Applicant or Agency Email Address | | | |

**Business Organization**

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

|  |
| --- |
| Full Legal Name and d/b/a Name of Business: |
| Legal Organization (mark only one):  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) |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | |  | | | |
| Sponsoring Government Agency | | Full name of agency contact person | | | |
|  |  | |  |  | -   - |
| Street Address | City | | State | ZIP | Phone Number |

Franchise

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | |  | | | |
| Parent Corporation Full Name | | Full name of corporation contact person | | | |
|  |  | |  |  | -   - |
| Street Address | City | | State | ZIP | Phone Number |

Corporation (Mark one of the following)

Public Non-Profit

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | |  | | | |
| Sponsoring Government Agency | | Full name of agency contact person: | | | |
|  |  | |  |  | -   - |
| Street Address | City | | State | ZIP | Phone Number |

Private Non-Profit\*

For Profit\*

Limited Liability Corporation\*

Other\* (describe business organization):

|  |
| --- |
|  |

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| --- |
| 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 list of additional owners):**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Full Name: | | | Social Security Number:     -    - | | | |
|  | |  | | |  |  |
| Street Address | | City | | | State | ZIP |
| -   - | -   - | | | -   - | | |
| Work Phone Number | Home Phone Number | | | Other Phone Number | | |

**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:**

|  |  |  |
| --- | --- | --- |
| Names | Locations (City/State) | Dates of Service |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  | | -   - | | |
| Name | Position Title | | Work Phone Number | | |
|  | |  | |  |  |
| Street Address | | City | | State | ZIP |

**List Names, Locations (City/State), and Dates of Services for every child care agency the individual has owned, operated, been employed by, or volunteered for:**

|  |  |  |
| --- | --- | --- |
| Names | Locations (City/State) | Dates of Service |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Attach list of additional members

**Initial Application Information**

**Complete this section 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)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| School Name | Street Address | City | State | ZIP |
| **Specialized Education** related to child care: | | | | |
| **Experience in working in social services, health and/or related field:** (List most recent experience first, attach additional sheets of paper if necessary): | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | -   - | /  /     to   /  / |
| Employer | Contact Person | Phone Number: | Dates Worked |
|  |  |  |  |
| Street Address | City | State | ZIP |

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | -   - | /  /     to   /  / |
| Employer | Contact Person | Phone Number: | Dates Worked |
|  |  |  |  |
| Street Address | City | State | ZIP |

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | -   - | /  /     to   /  / |
| Employer | Contact Person | Phone Number: | Dates Worked |
|  |  |  |  |
| Street Address | City | State | ZIP |

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|  |  | -   - | /  /     to   /  / |
| Employer | Contact Person | Phone Number: | Dates Worked |
|  |  |  |  |
| Street Address | City | State | ZIP |

Attach copy of your resume if available

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

|  |  |  |
| --- | --- | --- |
|  |  | -   - |
| Name | Address | Phone Number |

|  |  |  |
| --- | --- | --- |
|  |  | -   - |
| Name | Address | Phone Number |

|  |  |  |
| --- | --- | --- |
|  |  | -   - |
| Name | Address | Phone Number |

# Program and Services

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| --- |
| Who is your target population? |
| Please describe your program IN DETAIL: |

|  |  |
| --- | --- |
| Is your agency accredited?  Yes  No | If yes, accrediting organization: |

|  |
| --- |
| 1. Number and type of meals and snacks to be served: 2. Do you participate in the Child and Adult Care Food Program?  Yes  No 3. Do you  prepare and serve meals,   have meals catered, or  participants required to bring a sack lunch   1. 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)? |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1. 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) 2. List additional fees charged and amount of each, i.e. assessment fee, registration fee, transportation fee, therapy fee. | | | | | |
|  |  |  |  |  |  |
| Service | Fee | Service | Fee | Service | Fee |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1. If agency provides transportation, describe transportation plans, procedures and the vehicles utilized in the transportation. Include all vehicle license plate numbers: 2. Do you contract with a third party to provide any programs or services? Example: Transportation; Physical, Occupational, Art or Music Therapy  Yes  No   If yes, please describe:   1. You must attach a legible copy of all contracts for adult day services programs and services.   List your rates and rate frequency; full-time, part-time, daily, weekly, monthly, etc. | | | | | |
|  |  |  |  |  |  |
| Rate | Frequency | Rate | Frequency | Rate | Frequency |
|  |  |  |  |  |  |
| Rate | Frequency | Rate | Frequency | Rate | Frequency |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Days of Operation: | Monday | | Tuesday | | Wednesday | | Thursday | | Friday | Saturday | | Sunday |
| Hours of Operation: | am  to       pm | | am  to       pm | | am  to       pm | | am  to       pm | | am  to       pm | am  to       pm | | am  to       pm |
| Holidays:  Do you accept part-time enrollment?  Yes  No | | | | | | | | | | | | |
| List all funding sources: | | Private Pay | | Medicaid Waiver | | SSBG | | Long Term Care Insurance | | | Other | |

|  |
| --- |
| 1. Admission requirements and enrollment procedures: 2. Provision for emergency medical care: |

# Insurance

|  |  |  |
| --- | --- | --- |
| Vehicle Liability Insurance: | | |
| Name of Company |  | |
| Policy Number: | | Expiration Date: |
|  | | |
| General Liability Insurance: | | |
| Name of Company |  | |
| Policy Number: | | Expiration Date: |

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| 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 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** |
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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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** |
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# 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.

**STAFFING PATTERN 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)** | | | | | | | | | | | | | |
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**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 | | | | | | | | | | | | | |
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**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 Tennessee Department of Human Services (TDHS) *before* changing ownership or changing the organization of the adult day services agency.

“I understand that by my signature, I am authorizing TDHS to verify the information supplied in this application. I agree to abide by the licensing standards of the TDHS and the licensing laws (T.C.A. § 71-2-401 et seq.). I understand that the appropriate fee must be submitted to the TDHS 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 annual 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** | | |
| Five (5) – Nineteen (19) Participants | | | Twenty (20) – One hundred (100) participants | | | More than One hundred (100) participants | | |
|  | Annual Fee | $125 |  | Annual Fee | $200 |  | Annual Fee | $400 |

**Supporting Medicaid Recipients** - Agencies wishing to serve Medicaid recipients now or in the future (including any private pay customers who convert to Medicaid) must be determined compliant with all applicable Home and Community-Based Services (HCBS) Settings rules before they can receive Medicaid reimbursement for supporting individuals on Medicaid. More information about the HCBS Settings Rule requirements can be found on the DHS Adult Day Services websiteunder Resources for Providers.

**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): | Date |

|  |  |
| --- | --- |
|  |  |
| Signature of Owner or Authorized Representative | Date |