Department of Mental Health & Substance Abuse Services

INITIAL APPLICATION FOR LICENSE

TO OPERATE A FACILITY AND/OR SERVICE PROVIDING MENTAL HEALTH, SUBSTANCE ABUSE, OR PERSONAL SUPPORT SERVICES

INSTRUCTIONS: This application may be made by the individual owner, chief executive officer, executive director, or other member of the governing body on whom rests the authority and responsibility for maintaining standards, policies, and procedures for the facility/service to be operated. (Please type or print legibly.) This application and accompanying documents are to be submitted to the Office of Licensure in the region where license is to be issued.

1. DATE OF APPLICATION:

Month: _____ **Day:** _____ **Year:** _____

2. APPLICANT NAME(S) *if applying as individual/joint proprietor(s)* **OR CORPORATE NAME** *if registered with TN Secretary of State*:

_____

3. IDENTIFICATION OF PERSON WHO HAS OVERALL RESPONSIBILITY FOR THE AGENCY/COMPANY: For individual proprietors or partnerships, name one of the individuals listed in #2. For corporations, associations, or other organizations, this may be the chief executive officer, executive director, etc.

NAME: _____ TITLE: _____

PHONE NUMBER: _____ FAX NUMBER: _____ EMAIL ADDRESS: _____

❑ Check here if a management firm has been contracted to oversee the management of the facility and/or service.

Name of Management Firm and Account Manager: _____

NOTE: A copy of the contract between the corporation and the management firm listed above must be submitted with this application.

4. CONTACT INFORMATION OF INDIVIDUAL RESPONSIBLE FOR INVOICES AND COMPLIANCE DOCUMENTS:

NAME: _____ TITLE: _____

PHONE NUMBER: _____ FAX NUMBER: _____ EMAIL ADDRESS: _____

BILLING ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

5. ORGANIZATIONAL STRUCTURE: (check one of the following)

❑ Individual/Joint Proprietorship	❑ Partnership	❑ Association
❑ Limited Liability Corporation	❑ Church	❑ Government Agency or State University
❑ Non-Profit Corporation	❑ For Profit Corporation	❑ Other _____

6. CORPORATION/ASSOCIATION INFORMATION. Note: This item must be answered **only** by those applicants having a corporation, association, or other collective type of organizational structure. A corporation must submit a copy of its corporate charter as certified by the Tennessee Secretary of State. (Sole proprietors, partnerships, government agencies, and state universities do not complete this item.)

List below the names, titles or positions, and city/state of residence of each person having membership in the governing body of the corporation, association, church, or other organization. (For example, Owner/Co-Owner, President, Vice-President, Board of Director members, elders, etc.)

Name	Title/Position	City/State of Residence
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

(If necessary, continue listing on separate sheet and check here ❑.)

7. BACKGROUND AND HISTORY: Proof of citizenship or evidence of legal immigration, a Background Information Check form, and a Non-Criminal Justice Privacy Rights Statement must be submitted on the individual listed in item #3 and any additional individuals listed in #2. Additionally, a fingerprint background check through the Tennessee Bureau of Investigation is required for this individual. (A fingerprint background through the FBI or a background check conducted by a state-licensed private investigator is acceptable but must include a check of current and previous states of residence, if any.) If the individual chooses to be fingerprinted by the TBI, an appointment will be scheduled by the Office of Licensure. (Cost of background check is the responsibility of the individual.)

The following questions are to be answered about the individual listed in item #3 and any additional applicants listed in #2.

a. Has the applicant or any responsible person referenced above ever been convicted, or currently under any charges, for offense against the law? (Note: You may exclude traffic violations for which a fine of less than $100 was paid, and any offense that was committed before a person's eighteenth birthday and finally adjudicated in a juvenile court or under youth offender law.

❑ YES ❑ NO If YES, provide person's name, date and place of offense, type of charge, and action taken:

b. Has the applicant or any person responsible for the corporation ever held a license or certificate from this state, or any other state, to operate a facility/service for providing mental health, substance abuse, or personal support services, or services to persons in need of other protective or supportive services, such as a nursing home, residential home for the aged, child or adult day care, foster homes, etc.?

❑ YES ❑ NO If YES, provide person's name, dates of operation, facility/service name and location, and licensing agency/state dept:

c. Has the applicant or any person responsible for the corporation ever held a license or certificate in this state, or any other state, to practice a regulated profession (such as physician, nurse, facility administrator, social worker, attorney, psychologist, etc.), and had such license revoked, denied, or suspended?

❑ YES ❑ NO If YES, provide person's name, profession, date, state, and action taken against such license or certificate:

8. PERSONAL INFORMATION: The following questions are to be answered about the individual listed in item #3 and any additional applicants listed in #2.

a. Full Name: _____ Social Security Number: _____

Place of Birth: _____ Date of Birth: _____

b. Year and degree or grade of highest level of education achieved: Year: _____ Degree: _____

Name of school/college/university _____

c. Current home address: Street Address: _____

City/State/Zip: _____

d. If residing at current address less than five years, give previous address:

Street Address: _____

City/State/Zip: _____

e. List previous employment or business occupation for the past five years:

(If more than one individual and/or if additional space is needed to answer any of the above, attach separate sheet and check here ❑.)

9. REFERENCES: List below the name and address or email address of three individuals who can attest that the individual listed in item #3 and any additional applicants listed in #2 is of reputable character or reputation, and has the ability to operate a facility/service providing services to persons who are vulnerable to neglect, abuse, and exploitation. Individuals providing a reference may not be related to the applicant by marriage, blood, or in a vested business venture.

1. Name: _____

   Mailing address or email address: _____

2. Name: _____

   Mailing address or email address: _____

3. Name: _____

   Mailing address or email address: _____

(If more than one individual, attach separate sheet and check here ❑.)

10. ACCREDITATION/CERTIFICATION STATUS: **(OPTIONAL: Accreditation or certification of an applicant's facility/service is not required in order to be approved for license.)** Participation in any of the following accreditation or certification programs may qualify a facility/service to be deemed into compliance with certain programmatic rules of licensure. To be considered for a possible deemed status determination, the applicant must submit documentation showing current accreditation or certification status for the facility/services/programs covered by such status, the effective dates of the status, and the findings of the accrediting or certifying body, including any deficiencies with plans of correction. The following accreditation and certification programs are recognized by the Department of Mental Health and Substance Abuse Services; check any applicable participation:

- ❑ Accreditation of Health Care Organizations
- ❑ Division of Intellectual Disabilities Services (DIDS)
- ❑ The Joint Commission
- ❑ Other: _____
- ❑ Council on Accreditation
- ❑ Council on the Accreditation of Rehabilitation Facilities (CARF)
- ❑ Council on Quality and Leadership (CQL)

11. FINANCIAL RESOURCES: **(NOTE: This item only applies to applicants/corporations applying for an A&D Non-Residential Office-Based Opiate Treatment license.)** The applicant must show financial solvency and responsibility to operate a facility/service. The applicant must provide a proposed budget for the facility's operation, or the most recent fiscal report or financial statement or other information which is complete and sufficient in showing the total assets, liabilities and income of the applicant. The Licensure Application Addendum: Financial Statement Form available on the Office of Licensure website may be used in lieu of the fiscal report or financial statement.

12. DESCRIPTION OF FACILITY/SERVICES: The licensure rules identify and describe distinct categories of facilities/services which meet differing rules based on the type of service provided and the needs of the persons served. **A Licensure Addendum: Fact Sheet Form identifying the services to be provided must be submitted for each location to be operated by the applicant.**

13. APPLICATION/LICENSE FEE: The fee amount is based on the number of distinct, non-residential categories to be operated at each non-residential site and/or the number of service recipient beds for each distinct residential facility site. Fee schedule is listed in the Licensure Administrative Rules Chapter 0940-05-02.05. Upon receipt of Initial Application and Licensure Application Addendum: Fact Sheet Form, the Office of Licensure will send an invoice with the appropriate fee amount and mailing instructions. **FEES ARE NON-REFUNDABLE**.

CERTIFICATION OF APPLICATION. Certification of Application is to be signed by the individual applicant, in the case of a proprietorship or partners; or the CEO, President, Chairperson, or equivalent officer in the case of a corporation or other association; or the person charged with the oversight of the facility/service by the appointing authority in the case of a governmental agency or state university.

I hereby declare that this application and its accompanying attachments have been carefully read and completed, and to the best of my knowledge, they are true, correct and complete. I further declare my authority and responsibility to make this application and agree to comply with the rules promulgated under Tennessee Code Annotated, Title 33, Chapter 2, Part 4, for the conduct of a facility/service providing mental health, substance abuse, or personal support services.

_____	_____
SIGNATURE OF APPLICANT OR AUTHORIZED AGENT	TITLE
_____	_____
TYPE OR PRINT NAME	DATE

Send completed forms and accompanying documentation to appropriate regional office.

East Tennessee Regional Office 520 West Summit Hill Drive Suite 502 Knoxville, TN 37902 Telephone #: 865-594-6551 Fax #: 844-340-4482 Email: LicensureEast.fax@tn.gov	Middle Tennessee Regional Office 500 Deaderick Street 5th Floor, Andrew Jackson Bldg. Nashville, TN 37243 Telephone #: 615-532-6590 Fax #: 615-532-7856 Email: LicensureMiddle.fax@tn.gov	West Tennessee Regional Office 951 Court Avenue Memphis, TN 38103 Telephone #: 901-543-7442 Fax #: 844-844-5538 Email: LicensureWest.fax@tn.gov