



Tennessee Department of Mental Health
Office of Licensure and Review

LICENSURE APPLICATION FEE INVOICE

INSTRUCTIONS: Use the schedule below to determine the total amount of fees to be submitted. Do Not Send Cash. Make Check or Money Order payable to: State of Tennessee.

SEND PAYMENT AND COMPLETED INVOICE TO: TDMH FISCAL SERVICES SECTION ANDREW JOHNSON BLDG., 10TH FLOOR 710 JAMES ROBERTSON PKWY. NASHVILLE, TN 37243-0675

PLEASE TYPE OR PRINT THE FOLLOWING INFORMATION

NAME, MAILING ADDRESS OF PERSON/AGENCY SUBMITTING FEE: APPLICATION DATE
NAME ADDRESS CITY STATE ZIP TYPE OF LICENSE: INITIAL RENEWAL

NAME AND STREET ADDRESS OF SERVICE(S) AND/OR FACILITY(S) FOR WHICH FEE SUBMITTED: (Use additional pages if needed.) (Copy of Page 2 of Renewal Application acceptable.)

NAME Email Address: STREET/RURAL ROUTE RR BOX # CITY ZIP COUNTY

COMPUTE THE AMOUNT OF TOTAL FEE:

NON-RESIDENTIAL SERVICE AND/OR FACILITY FEES

Table with 5 rows: No. of Sites Operating One (1) Distinct Category of Services and/or Facility: x \$ 810.00=...\$; No. of Sites Operating Two (2) Distinct Categories of Services and/or Facilities: x \$ 1,010.00=...\$; No. of Sites Operating Three (3) Distinct Categories of Services and/or Facilities: x \$ 1,220.00=...\$; No. of Sites Operating Four (4) Distinct Categories of Services and/or Facilities: x \$ 1,420.00=...\$; No. of Sites Operating More Than Four (4) Distinct Categories of Services and/or Facilities: x \$ 1,620.00=...\$

RESIDENTIAL FACILITY FEES

Table with 5 rows: Capacity of Two to Three (2-3) Beds at Site(s) x \$ 200.00=...\$; Capacity of Four to Ten (4-10) Beds at Site(s) x \$ 280.00=...\$; Capacity of Eleven to Fifteen (11-15) Beds at Site(s) x \$ 410.00=...\$; Capacity of Sixteen to Fifty (16-50) Beds at Site(s) x \$ 810.00=...\$; Capacity of More Than Fifty (50) Beds at Site(s) x \$ 1,220.00=...\$

Fees for Mental Health Hospitals and Mental Retardation Institutional Facilities

Total Number of Beds at All Sites x \$175.00 (per bed) = \$

GRAND TOTAL OF FEES = \$

FOR TDMHDD OFFICE USE ONLY—DO NOT WRITE IN THE SPACE BELOW

1. FISCAL SERVICES SECTION: Date Fee Rec'd: Amnt. Rec'd: \$ Receipt Number # Received By: 2. REGIONAL LICENSURE OFFICE VERIFICATION: Date Fee Verified: Correct Fee: Correct. Insufficient. Overpayment. Verified By: