



STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH
OFFICE OF LICENSURE AND REVIEW

APPLICATION FOR LICENSE RENEWAL

TO CONDUCT A FACILITY AND/OR SERVICE PROVIDING
MENTAL HEALTH, MENTAL RETARDATION, DEVELOPMENTAL DISABILITY, ALCOHOL AND DRUG ABUSE, OR PERSONAL SUPPORT SERVICES

INSTRUCTIONS: This application form is for use by applicants who currently hold license(s) and are applying for renewal of said license(s). This application for license renewal may only be used when the applicant is applying to continue present facility/service operation(s) under the same ownership or operator, and under the same conditions and classifications of the currently held license(s). Please read carefully and complete this form and its attachments in full. Please type or print legibly. This application may be made by the individual owner, chief executive officer, 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.

1. DATE OF APPLICATION.

Month: _____ Day: _____ Year: _____

2. IDENTIFICATION OF APPLICANT. Identify the person, partnership, corporation, association, or governmental agency applying to lawfully establish, conduct, operate or maintain a facility or service:

3. APPLICANT'S ADDRESS. Give the street address (and mailing address, if different) of the applicant's primary place of business or residence:

Street Address: _____

Mailing Address: _____

City: _____ Zip: _____ County: _____

4. APPLICANT'S TELEPHONE NUMBER(S) AND FAX NUMBER(S):

5. APPLICANT'S ELECTRONIC MAIL (E-MAIL) ADDRESS:

6. CHIEF EXECUTIVE OFFICER OR DIRECTOR. Identify below the person who will be responsible for the overall daily management and oversight of the facility/service to be operated by the applicant. This person may be the same as the individual applicant(s) in the case of a proprietorship or partnership. This person may be someone who is hired or appointed by the applicant, such as in the case of a corporation, association or other organization which employs a chief executive officer, director, etc. Or, the person may be employed by a management firm with which the applicant has contracted to oversee the daily operation of the facility/service. Check one (1) of the following statements:

The facility/service will be managed and overseen on a daily basis by the individual applicant(s) named in item (2) above.

The facility/service will be managed and overseen on a daily basis by a person hired by the applicant. Identify this person

Name: _____ Title: _____

The facility/service will be managed and overseen by a person employed by the management firm under contract with the applicant.

Identify the person and the firm: (See note below)

Name: _____ Title: _____

Firm's Name: _____

Firm's Address: _____

NOTE: A copy of the current contractual agreement between the applicant and the management firm must be on file with the Department. If the copy previously submitted is of a contract still in effect, please check here. ___ If a new contract is in effect, a copy of the contract/agreement must be submitted with this application. If a new person has been appointed or hired to serve as chief executive officer or director responsible for overall daily management of the Licensee's facilities or services, the individual(s) must supply fingerprint samples for a criminal history/background records check to be conducted by the Tennessee Bureau of Investigation or release information for a criminal background check by a state-licensed private investigation company. The criminal background check shall include previous state(s) of residence, if any. A copy of the criminal background investigation report must be submitted to the appropriate regional licensure office.

8. **ANNUAL REPORT.** Read the following statements carefully. Answer each question by checking an appropriate box and supplying the requested information for any question answered "Yes".

- a. Has the applicant; or the applicant's chief executive officer, director or other person charged with daily management and oversight responsibility for a facility/service, or has any member- of the applicant's governing body (board of directors, etc.) been convicted of, or currently charged with, any offense against the law which has not been previously reported to the Department? (You may exclude any traffic violation for which a fine of \$100.00 or less was paid and any offense which was committed before the person's eighteenth birthday and which was finally adjudicated in a juvenile court or under a youth offender law.)
 NO YES If yes, give the person's name, the nature, date and place of the charge, and the court ruling or current disposition.

- b. Has any negative sanction or action been taken against any other license (if any) held by the applicant from any other state agency of Tennessee from any other state?
 NO YES If yes, explain: _____

- c. Has any negative sanction or action been taken against accreditation or certification (If any) currently or previously held by the applicant? (Including Medicaid/Medicare certification.)
 NO YES If yes, explain: _____

- d. Has there been any investigation by federal, state, or local authorities (other than by this Department) into any allegations of abuse, neglect, dereliction of duty or mismanagement in the operation of any facility/service of the applicant which may not have been neglect dereliction previously reported to this Department?
 NO YES. If yes, explain: _____

- e. Has any negative sanction or action been taken against professional license or certification held by the individual owner or operator, or the applicant's chief executive officer, director of any other person charged with overall management, supervisory, habilitation, or treatment responsibility for a facility/service? (For example, licensed physician, nurse, counselor, psychologist, attorney, etc.)
 NO YES If yes, explain: _____

- f. Have you begun, or do you plan to begin operating any other facility/service for the provision of mental health mental retardation, alcohol and drug abuse, and personal support services not currently authorized by your license(s)? NO. YES. If yes, immediately contact the Department of Mental Health and Developmental Disabilities, Office of Licensure. Operation of a facility/service without a license is violation of state law. (TCA 33-2-405)

9. **FINANCIAL RESOURCES.** (Note: This item **does not** apply to state-operated facilities/services.) The applicant must show continued financial solvency and responsibility to operate facility/service. The applicant must provide a financial statement or other information which is current, complete and sufficient in showing the total assets, liabilities and income of the applicant for the operation of the facility/service to be licensed. Attach copy of the most recent (within [12] months) fiscal report or financial statement. The financial statement form included with this application may be used for completing a financial statement. (A FINANCIAL STATEMENT MUST ACCOMPANY THIS APPLICATION.)

10. **CORPORATION/ASSOCIATION INFORMATION.** This item applies only to applicants who have incorporated or associated type of organizational structure, such as, corporations, associations, and churches. (This item does not apply to proprietor ships, partnerships, governmental agencies, or state universities.) A current and up-to-date listing of the members of the organization's governing body must be included with this application

11. **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, the facility/service 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; check any applicable participation:

- | | |
|---|---|
| <input type="checkbox"/> The Joint Commission | <input type="checkbox"/> Council on Quality and Leadership (CQL) |
| <input type="checkbox"/> Council on Accreditation of Rehabilitation Facilities (CARF) | <input type="checkbox"/> Social Security Act, Title XIX, Public Law 89-98, as amended (Medicaid) for Intermediate Care Facilities for the Mentally Retarded (ICF/MR) only |
| <input type="checkbox"/> Council on Accreditation | <input type="checkbox"/> Division of Intellectual Disabilities Services (DIDS) |
| <input type="checkbox"/> National Commission on Accreditation for Special Education Services (NCASES) | |

12. **APPLICATION PROCESSING FEE FOR LICENSE RENEWAL.** A fee is required to be submitted by the applicant for the processing of the application for license renewal. The amount of total fee to be submitted is based on the number of distinct, non-residential categories to be operated at each non-residential site; and on the total number of service recipient beds to be operated at each distinct, residential site. (This information is found on the face of the license certificate(s) you currently hold.)

A "LICENSURE APPLICATION FEES INVOICE FORM" is enclosed with this application. Use the invoice form to compute the amount of fee to be submitted. The invoice form and your fee must be submitted separately from this application form to the address of the Fiscal Services Office given on the invoice form. **Do not send fees or invoice forms to the Office of Licensure. Fees are to be submitted by check or money order made payable to the State of Tennessee. Do Not Send Cash. Applications will not be processed until the correct fee has been submitted. FEES ARE NON-REFUNDABLE.**

13. **CERTIFICATION OF APPLICATION.** This certification is to be read and signed by the applicant. The person signing below must be the individual applicant in the case of a proprietorship or partnership; or the chairperson or other 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, R 2, PART 4, FOR THE CONDUCT OF A FACILITY/SERVICE PROVIDING MENTAL HEALTH, MENTAL RETARDATION, DEVELOPMENTAL DISABILITY, ALCOHOL AND DRUG ABUSE, OR PERSONAL SUPPORT SERVICES.

SIGNATURE OF APPLICANT OR AUTHORIZED AGENT:

DATE OF SIGNATURE:

Type or Print Name and Title of Person Signing Above:

IMPORTANT-SPECIAL INSTRUCTIONS: This renewal application form with any other application information attachments is to be submitted to your region's Office of Licensure. However, the application fees and the invoice form for the fees must be submitted to the Fiscal Services office address listed on the application fees invoice form. Sending the application information and the fees correctly and simultaneously to the appropriate and separate offices will help ensure a timely beginning on the processing of your application for a license.

ADDRESSES FOR REGIONAL LICENSURE OFFICES

EAST TENNESSEE
 STATE OFFICE BLDG.
 531 HENLEY STREET, SUITE 706
 KNOXVILLE, TN 37902
 TELEPHONE #: (865) 594-6551
 FAX #: (865) 594-5248

MIDDLE TENNESSEE
 ANDREW JOHNSON TOWER, 12TH FL
 710 JAMES ROBERTSON PARKWAY
 NASHVILLE, TN 37243
 TELEPHONE #: (615) 532-6590
 FAX #: (615) 532-7856

WEST TENNESSEE
 170 NORTH MAIN STREET
 12TH FLOOR
 MEMPHIS, TN 38103
 TELEPHONE #: (901) 543-7442
 FAX #: (901) 543-7008

(FOR TDMH OFFICE USE ONLY-Do Not Write in the Space Below.)	
Date Application Reviewed:	Application Reviewed by:
Action Taken: <input type="checkbox"/> Application Approved in Full. <input type="checkbox"/> Application Approved in Part for Following Facilities:	
<input type="checkbox"/> Application Denied for the Following Reason(s): _____	
<input type="checkbox"/> Application Withdrawn by Applicant: _____	