



STATE OF TENNESSEE  
DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES  
OFFICE OF LICENSURE

**INITIAL APPLICATION FOR LICENSE**

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

**INSTRUCTIONS:** 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: \_\_\_\_\_ Date: \_\_\_\_\_ 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 E MAIL ADDRESS:

6. ORGANIZATIONAL STRUCTURE. Identify the type of organizational structure of the applicant's governing body; check one (1) of the following:

- Individual (Proprietorship)
- Partnership
- Church
- Nonprofit Corporation
- For Profit Corporation

- Association
- Government Agency
- State University
- Other: \_\_\_\_\_

7. 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 and/or 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: (NOTE: A copy of the management contract between the applicant and the firm listed below must be submitted with this application.)

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Firm's Name: \_\_\_\_\_

Firm's Address: \_\_\_\_\_



- b. Has the applicant, or any responsible person referenced above, ever held a license from this state, or any other state, to conduct a facility/service for providing mental health, alcohol and drug abuse, or personal support services?  
 NO  YES from the Tennessee Department of Mental Health and Substance Abuse Services  YES from the following state and agency for the following facility/service and location: \_\_\_\_\_

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

- c. Has the applicant, or any responsible person referenced above, ever held a license or certificate from this state, or any other state, to operate a facility/service providing 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 home, etc?  
 NO  YES If answered yes, give person's name, dates of operation, facility/service name and location, and licensing agency:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

- d. Has the applicant, or any responsible person reference above, ever held a license or certificate to practice a regulated profession in this state, or any other state, and had such license revoked, denied or suspended? (Such as: physician, nurse, facility administrator, social worker, attorney, psychologist, etc.)  NO  YES If answered yes, give person's name, profession, date, place and action taken against such license:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

(If additional space is needed to answer any of the above, attach separate sheet and check here  ).

**10. EDUCATION AND EXPERIENCE. Important:** The following information is to be supplied about the individual applicant(s) in the case of proprietorships and partnerships, and when applicable, about the person identified in item (7) of this application as the chief executive officer, director or other person charged with the overall daily management and oversight of the facility/service to be operated by the applicant.

- a. Give full name(s) (including maiden name(s) when applicable), place(s) and date(s) of birth, Social Security number(s) of the person(s) for whom this information is being supplied:

Full Name	Date of Birth	Place of Birth	Social Security Number

- b. Give the place, date, and degree or grade of the highest level of education achieved: \_\_\_\_\_

\_\_\_\_\_

- c. If residing at current address less than five (5) years, give previous address: \_\_\_\_\_

\_\_\_\_\_

- d. List previous employment or business occupation for the past five (5) years:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

(If additional space is needed for any of the above items, attach separate sheet and check here  .)



16. **APPLICATION PROCESSING FEE.** A fee is required to be submitted by the applicant for the processing of the application for license. 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 facility site.

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 are to 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.

16. **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 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, ALCOHOL AND DRUG ABUSE, OR PERSONAL SUPPORT SERVICES.

IF YOUR AGENCY CONTRACTS WITH THE TENNESSEE DEPARTMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES, PLEASE PROVIDE YOUR EDISON VENDOR ID.

SIGNATURE OF APPLICANT OR AUTHORIZED AGENT:

DATE OF SIGNATURE:

Type or Print Name and Title of Person Signing Above:

**IMPORTANT-SPECIAL INSTRUCTIONS:** This application form with its fact sheets and other application information attachments are 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**  
 520 West Summit Hill Drive  
 Suite 301  
 Knoxville, TN 37902  
 Telephone #: (865) 594-6551  
 Fax #: (865) 594-5248

**MIDDLE TENNESSEE**  
 Andrew Jackson Tower  
 5th Floor  
 500 Deaderick Street  
 Nashville, TN 37243  
 Telephone #: (615) 532-6590  
 Fax #: (615) 532-7856

**WEST TENNESSEE**  
 951 Court Avenue  
 Memphis, TN 38103  
 Telephone #: (901) 543-7442  
 Fax #: (901) 543-7008

(FOR TDMHSAS OFFICE USE ONLY-Do Not Write in the Space Below)

Date Application Reviewed:	Application Reviewed By:		
<p>Application Review Checklist:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top; border: none;"> <input type="checkbox"/> All Required Info. Completed  <input type="checkbox"/> Letters of Reference Returned  <input type="checkbox"/> All Fact Sheet Forms Submitted, if applicable:  <input type="checkbox"/> Criminal Background Check  <input type="checkbox"/> Management Contract (if any) Submitted  <input type="checkbox"/> Evidence of Appropriate Zoning, if applicable  <input type="checkbox"/> Other Special Investigation or Action Completed: _____         </td> <td style="width: 50%; vertical-align: top; border: none;"> <input type="checkbox"/> Financial Statement Submitted  <input type="checkbox"/> Correct Processing Fee(s) Submitted  <input type="checkbox"/> Governing Board Members Listed  <input type="checkbox"/> Proof of Citizenship or Legal Immigration  <input type="checkbox"/> Evidence (if any) for Deemed Status Determination         </td> </tr> </table>		<input type="checkbox"/> All Required Info. Completed <input type="checkbox"/> Letters of Reference Returned <input type="checkbox"/> All Fact Sheet Forms Submitted, if applicable: <input type="checkbox"/> Criminal Background Check <input type="checkbox"/> Management Contract (if any) Submitted <input type="checkbox"/> Evidence of Appropriate Zoning, if applicable <input type="checkbox"/> Other Special Investigation or Action Completed: _____	<input type="checkbox"/> Financial Statement Submitted <input type="checkbox"/> Correct Processing Fee(s) Submitted <input type="checkbox"/> Governing Board Members Listed <input type="checkbox"/> Proof of Citizenship or Legal Immigration <input type="checkbox"/> Evidence (if any) for Deemed Status Determination
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<p>Application Approval Status:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top; border: none;"> <input type="checkbox"/> Application Approved in Full for All Facilities/Services  <input type="checkbox"/> Application Approved in Part for Following Facilities: _____         </td> <td style="width: 50%; vertical-align: top; border: none;"> <input type="checkbox"/> Application Denied in Full for Following Reason(s):  <input type="checkbox"/> Application Withdrawn by Applicant.         </td> </tr> </table>		<input type="checkbox"/> Application Approved in Full for All Facilities/Services <input type="checkbox"/> Application Approved in Part for Following Facilities: _____	<input type="checkbox"/> Application Denied in Full for Following Reason(s): <input type="checkbox"/> Application Withdrawn by Applicant.
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# Licensure Background Check Information

Personal Information	
Social Security Number	
First Name	
Middle Name	
Last Name	
Date of Birth	
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female
Citizenship	
Place of Birth (State/Country or Region)	
Home Address With City, State and Zip Code.	
Country of Citizenship	
*Home Phone	
Will Employee Be Transporting Children, Adults, Handicapped, or Hazardous Material?	
Licensed To Drive?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Driver License Number & State	
Employer or Agency Name	
Employer Address With City, State and Zip Code.	
Contract Agency Name	
Payment for background check to be made	<input type="checkbox"/> Money Order <input type="checkbox"/> Credit Card
Vital Information	
Height	
Weight	
Race	<input type="checkbox"/> WHITE <input type="checkbox"/> BLACK <input type="checkbox"/> ASIAN/PACIFIC ISLANDER <input type="checkbox"/> AMERICAN INDIAN/ALASKAN   <input type="checkbox"/> HISPANIC
Hair Color	<input type="checkbox"/> BALD <input type="checkbox"/> BLACK <input type="checkbox"/> BLOND <input type="checkbox"/> BROWN <input type="checkbox"/> GREY <input type="checkbox"/> RED <input type="checkbox"/> SANDY <input type="checkbox"/> WHITE
Eye Color	<input type="checkbox"/> BLACK <input type="checkbox"/> BLUE <input type="checkbox"/> BROWN <input type="checkbox"/> GREY <input type="checkbox"/> GREEN <input type="checkbox"/> HAZEL <input type="checkbox"/> PINK
Information Below For Office Use Only	
AGENCY ORI	
CASE NUMBER	339.01
PAYMENT MADE BY	
AGENCY PROVIDER #	
AGENCY PROVIDER SUFFIX	
TRANSACTION DATE/TIME	
HIRE DATE	
REPRINT	<input type="checkbox"/> YES <input type="checkbox"/> NO

Fields marked with a "\*" are optional. All other fields are mandatory. Please check your information to insure accuracy. Failure to do so may prevent or delay the processing of your fingerprints and employment.  
MH-5460 (Rev. 10/1/14)