**APPLICATION FACT SHEET**

**INSTRUCTIONS:** This form is an addendum to the application for license and is to be used to describe the facility/service to be operated at a given site. One (1) fact sheet form is to be completed for each distinct facility/service category to be operated at a given site. This form must be completed when making application for initial license to operate a newly established facility/service. ***This form is also to be used by any current licensee who is applying for a license to operate an additional facility/service, to relocate a currently licensed facility/service to another site or building, to expand an existing facility/service, or to change the distinct facility/service category or occupancy of a currently licensed facility/service***.

**1. NAME OF AGENCY** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. DATE OF APPLICATION** Month: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. PURPOSE:** Identify the reason for the completion of this fact sheet: (Check one)

[ ]  Initial application by new applicant for license to operate a newly established facility/service.

 (A completed "Initial Application for License" form must accompany this fact sheet.)

[ ]  Application by a current licensee for license to establish and operate an additional facility/service.

[ ]  Application by a current licensee to relocate a currently licensed facility/service to another site or building.

[ ]  Application by a current licensee for approval of major renovation; change in use or occupancy; or expansion of the physical plant of a currently licensed facility/service.

**4. NAME AND LOCATION OF FACILITY/SERVICE.** Identify this facility/service as it is to be named by the applicant, known to the public, and listed on the license:

|  |  |
| --- | --- |
| **Agency Name** | **Facility/Service Telephone Number**  |
| **Street Address of Facility/Service Where License Will Be Issued** |
| **Email Address of Facility/Service** |
| **City /Town** | **Zip Code** | **County** |

Is the location of the facility/service inside of city limits? [ ]  YES [ ]  NO

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

**5. DISTINCT CATEGORY.** Identify the distinct category of this facility/service as defined in the licensure rules:

**Selections can ONLY be made from one box (the shaded box requires only one service selected and the non-shaded box can have multiple selections). Both boxes can not be utilized on one form.**

|  |  |
| --- | --- |
| **CHECK ONLY ONE**A separate Fact Sheet must be completed for each service requested below: [ ]  ID Adult Habilitation Day - Center Based[ ]  DD Adult Habilitation Day - Center Based[ ]  DD Pre-School - Center Based[ ]  ID & DD Institutional Habilitation [ ]  ID & DD Residential Habilitation[ ]  ID & DD Boarding Home | Please check **ALL** services that are requested to be run out of the business office: [ ]  ID Adult Habilitation Day - Community Based[ ]  DD Adult Habilitation Day - Community Based [ ]  DD Pre-School - Community Based [ ]  DD Semi-Independent Living[ ]  ID Semi-Independent Living[ ]  ID & DD Supported Living [ ]  Support Coordination[ ]  ID & DD Placement Services [ ]  ID & DD Diagnosis & Evaluation [ ]  Personal Support Services [ ]  ID & DD Respite Care Services |

Questions A-G apply to the following Distinct Categories: Adult Habilitation Day Residential Habilitation

Placement Services Semi-Independent Living

Supported Living

1. The service setting is located in a building that is also a publicly operated facility that provides inpatient

institutional treatment (NF, IMD, ICF/IID, Hospital)? [ ]  YES [ ]  NO

1. The service setting is located in a building on the grounds of, or immediately adjacent to, a public institution?

 [ ]  YES [ ]  NO

1. The provider does own or operate multiple homes located on the same street (excluding duplexes and

multiplexes, unless there is more than one on the same street)? [ ]  YES [ ]  NO

1. The service setting is located in a gated/secured “community’ for people with disabilities? [ ]  YES [ ]  NO
2. The service setting or dwelling is located in a farmstead or disability-specific community? [ ]  YES [ ]  NO
3. The service setting is designed specifically for people with disabilities? [ ]  YES [ ]  NO
4. Individuals who reside in the setting are primarily or exclusively people with disabilities? [ ]  YES [ ]  NO

Do you plan on receiving federal reimbursement for providing this service? [ ]  YES [ ]  NO

 If YES, through which waiver(s)? [ ]  Home and Community Based Services (HCBS)

[ ]  CHOICES - Community Living Supports (CLS)

[ ]  ECF CHOICES – Employment & Community First (ECF)

[ ]  Katie Beckett - Part A, Katie Beckett - Part B

**6. SITE MANAGER/DIRECTOR.** Identify the person who is charged with the overall daily management of this facility/service:

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| --- | --- |
| Name of Person: | Title/Position: |

 Has this person ever been convicted of or currently under any charges of a felony offense under the law? [ ]  NO [ ]  YES if yes, attach an explanation of the date, type and place of the charge, court action taken, or current disposition.

**NOTE: ITEMS NUMBERED (7) THROUGH (23) DO NOT APPLY TO PERSONAL SUPPORT SERVICE**

**7**. **NUMBER OF BUILDINGS**. Identify the number of buildings on the site of this facility which are to be used for service recipient residences or other service recipient programs: \_\_\_\_. If more than one (1) building is to be used on the site of this facility category, then list each building by its name or location on the site, and give the primary use of each building and the number of service recipients to reside or to be served in each building.

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| **Name/Location of Building** **Primary Use of Building** **No. of Persons Supported** |
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(If necessary, attach a separate sheet, and check here [ ] .)

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**8. OWNERSHIP OF PREMISES**. Identify the ownership of the buildings, premises or real property in which this facility is to be located.

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| [ ]  Owned by the applicant free of mortgage[ ]  Mortgage Lender[ ]  Leased from: **{** [ ]  Donated by:  | [ ]  Owned by the State of TennesseeName: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City & State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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**9. NUMBER OF PERSONS SUPPORTED**. Indicate the number of persons supported to reside or to be served in this facility: \_\_\_\_\_\_.

Are any of these people six years of age or younger? [ ]  NO [ ]  YES

**10. SQUARE FOOTAGE**. Total occupiable space of facility in square feet: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

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

**11. HOURS OF OPERATION**. Indicate the normal days and hours of facility's operation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**12. SHARED OCCUPANCY**. Are other activities or occupancies to occur in this building(s) which are not under the control of the licensee/applicant? [ ]  NO [ ]  YES

If yes, describe:

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**13. MOBILE, NON-AMBULATORY PERSONS SUPPORTED**. Are mobile, non-ambulatory persons (persons using wheelchairs, walkers, etc.) to be served in this facility? ❑ NO ❑ YES if yes, are these persons capable of transferring unassisted from a bed or other fixed position into the wheelchair or other mobility device and traversing a predefined means of egress from the facility? ❑ NO ❑ YES

**14. PERSONS SUPPORTED SELF-PRESERVATION**. Are all of the persons to be served in this facility to be persons who are capable of

self-preservation by responding to an emergency signal, including prompting by voice, and following a pre-taught evacuation procedure from the

 facility? [ ]  NO If “NO” – How many persons are not capable of self-preservation? \_\_\_\_\_\_\_

[ ]  YES

Any persons with hearing loss? [ ]  NO [ ]  YES

Any persons with visual impairment? [ ]  NO [ ]  YES

**15. SECURITY MEASURES**. Are security measures, such as exit doors or windows locked to prevent egress, restraints, or seclusion, which

 are beyond the person's control to be used in this facility? [ ]  NO [ ]  YES If yes, explain:

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**16. VOCATIONAL ACTIVITIES**. Are vocational activities to be conducted in this facility? (Activities of an industrial or productive nature such as

contract work, assembling, packaging, woodworking, metalworking, painting, stripping, etc.) [ ]  NO [ ]  YES

**17. FOOD SERVICE**. Are food service, food preparation, and meals to be provided by this facility on a regular basis to the persons supported by the facility? [ ]  NO [ ]  YES

**18. BATHROOM ACCOMMODATIONS**. Number of separate bathtubs or shower stalls: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Number of toilets: \_\_\_\_\_\_\_\_\_

Number of urinals: \_\_\_\_\_\_\_\_\_\_. Number of sinks or hand lavatories in bathrooms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**19. BUILDING CONSTRUCTION**. This facility is to be located in: (check one) [ ]  A building to be constructed or under construction.

❑ An existing building to be adapted for the facility's use. Number of stories or floors: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Basement: [ ]  NO [ ]  YES Indicate the building's type of construction: [ ]  Wood frame with wood, shingle or metal siding.

❑ Wood +frame with Brick Veneer. [ ]  Masonry Block, no wood frame members. [ ]  Masonry Block with wood frame members.

❑ Reinforced concrete with steel members. [ ]  Other, describe:

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| --- |
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**20. WATER/SEWER**. Is drinking water furnished by a well/spring located on the property? [ ]  NO [ ]  YES

 Is sewage handled by a septic tank located on the property? [ ]  NO [ ]  YES

**NOTE: ITEMS 21 THROUGH 23 ARE TO BE ANSWERED ONLY FOR RESIDENTIAL FACILITIES**.

**21. LIVE-IN STAFF**. Are staff members to reside or have sleeping arrangements in this facility?

 [ ]  NO [ ]  YES If yes, how many such persons: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**22. TOTAL OCCUPANCY**. Total number of persons including those supported, staff, family, etc. to reside in this facility: \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_

**23. NUMBER OF ROOMS**. Bedrooms (Persons Supported): \_\_\_\_\_\_\_\_\_\_\_ \_\_ Bedrooms (Staff or other): \_\_\_\_\_\_\_\_\_ Living Room: \_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**24. OTHER**. Use this space to provide any additional information or to explain any of the above items.

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**IDENTIFICATION OF INFORMATION**. The information contained in this fact sheet is an addendum to, or a part of the application for a license. The person signing below must be the individual applicant in the case of a proprietorship or partnership; or the chairperson or equivalent officer of the governing body in the case of a corporation or other association making application; or in the case of a governmental agency or state university, the person charged by the appointing authority with responsibility for the operation of the facility/service.

I HEREBY DECLARE THE INFORMATION CONTAINED IN THIS LICENSURE APPLICATION ADDENDUM TO BE TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I FURTHER DECLARE MY AUTHORITY AND RESPONSIBILITY TO CERTIFY THIS INFORMATION IN MAKING APPLICATION FOR LICENSE TO CONDUCT THE FACILITY DESCRIBED HEREIN. I AGREE TO COMPLY WITH THE RULES PROMULGATED FOR THE OPERATION OF THIS FACILITY/SERVICE UNDER TENNESSEE CODE ANNOTATED TITLE 33, CHAPTER 2, PART 4.

**Signature of Applicant or Authorized Agent:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Printed Name and Title of Person Signing Above**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_