STATE OF TENNESSEE
DEPARTMENT OF HEALTH
DIVISION OF HEALTH LICENSURE AND REGULATION
OFFICE OF HEALTH CARE FACILITIES
665 MAINSTREAM DRIVE, SECOND FLOOR
NASHVILLE, TENNESSEE 37243
(615) 741-7221

HOME FOR THE AGED
RENEWAL APPLICATION

All applicable laws, rules, policies, and guidelines affecting your practice are available for viewing at http://tennessee.gov/health/topic/hcf-professionals. Please check this website periodically for updates.

Name of the Facility/Agency _____

Facility License Number _____

Location of the Facility:

Street _____ City _____

County _____ State _____ Zip _____

Phone Number (____) _____ Fax Number (____) _____

Twenty-four (24) Hour Emergency Phone Number (____) _____

E-Mail Address _____

Total Number of Licensed Beds _____

Does this facility have a secured unit? Yes _____ No _____ Number of Secured Beds _____

Does this facility provide Adult Day Care services? Yes_____ No_____ If yes, how many beds_____

Does this facility provide Pet Therapy? Yes____ No_____

Administrator _____ Certification Number _____

Mailing address if different from the Facility location address:

Name _____

Street _____

City _____ State _____ Zip _____

Ownership of Building:

Name _____ Phone Number (____) _____

Street _____

City _____ State _____ Zip _____

OWNERSHIP OF BUSINESS:

1. a. Check the type of Legal Entity:
   _____ Individual _____ Partnership _____ Corporation _____ Limited Liability Company
   _____ Church Related _____ Government/County _____ Other

   b. Check One: _____ For Profit _____ Non-profit

   c. Legal Entity checked in 1.a:

   Name _____ Phone Number (____) _____

   Street _____

   City _____ State _____ Zip _____

   d. List name(s) and address(es) of individual owner, partners, directors of the corporation, or head of the governmental entity:

   _____
   Name Address City, State, Zip

   _____
   Name Address City, State, Zip

   _____
   Name Address City, State, Zip

   (If additional space is needed, please use a separate sheet)

2. a. Is your facility/organization accredited by a **federally approved** accrediting body (i.e., JCAHO, CARF, etc)?

   Yes _____ No _____ Expiration Date _____

   b. Is your facility/organization deemed by a **federally approved** accrediting body (i.e., JCAHO, CARF, etc)?
   Yes _____ No _____ Expiration Date _____

3. a. Is this facility chain affiliated? Yes_____ No_____

   b. If yes, list name, address and phone number of the parent company.

   Name _____ Phone Number (____) _____

   Street _____

   City _____State _____ Zip _____

4. a. If a corporation, is there a holding company/parent corporation? Yes _____ No _____

b. If yes, list the name, address and phone number of the holding company/parent corporation.

Name _____ Phone Number (_____) _____

Street _____

City _____ State _____ Zip _____

5. a. Are any owners of the disclosing entity also owners of other health care facilities in Tennessee and/or other states? Yes _____ No _____

b. If yes, list names and addresses of all such facilities:

_____

_____

_____

6. a. Do you have a contract with a management firm to operate this facility? Yes _____ No _____

If yes, specify dates: From _____ To _____

b. If yes, specify name of firm: _____

Street _____ Phone Number (_____) _____

City _____ State _____ Zip _____

FEES: REFER TO THE FEE RENEWAL INVOICE ENCLOSED WITH THIS APPLICATION. FEES ARE NON-REFUNDABLE.

VERIFICATION BY APPLICANT:

Signee for application verifies that he or she is of responsible character and able to comply with the minimum standards and regulations established by Tennessee pertaining to the type of facility or agency for which application for licensure is made and with the rules promulgated under Tennessee Code Annotated (TCA) §68-11-201.

Signee also verifies that a policy has been implemented to inform all employees of their obligation under TCA §71-6-103 to report incidents of abuse or neglect.

_____ _____ _____

Applicant Signature Title or Position Date