PROFESSIONAL SUPPORT SERVICES
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 _____

Administrator _____

Mailing address if different from the Facility location address:

Name _____

Street _____

City _____ State _____ Zip _____

Ownership of Building:

Name _____ Phone Number (____) _____

Street _____

City _____ State _____ Zip _____

1. Does your facility have a current provider agreement with DIDD to provide Professional Support Services?

   Yes_____ No _____

   (Please note before renewal can be finalized a copy of your current provider agreement MUST be attached).

2. Geographic area served by Agency: (check appropriate region or regions).

   _____ East _____ Middle _____ West

Check type of services provided:

a. Skilled Nursing _____ c. Occupational Therapy _____

b. Physical Therapy_____ d. Speech Therapy _____

Site Codes:

1. Number of site codes: _____

Code number, address and phone number of each site: ***(If additional space is needed, please use a separate page)***

_____

_____

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 owners, 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 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 _____

3. 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 _____

4. 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:

_____

_____

_____

5. 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