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: _____

8. CORPORATION/ASSOCIATION INFORMATION. (Note: This item must be answered **only** by those applicants having a corporation, association or other collective type of organizational structure. Proprietorships, partnerships, governmental agencies and state universities do not complete this item.) Complete parts a. and b. below:

a. List below the names, titles or positions, and places of residence of each person having membership in the governing body of the corporation, association, church, or other organization making this application: (For example, the board of directors, elders, etc.)

Name	Title / Position	Place of Residence

(If necessary, continue listing on separate sheet and check here ❑.)

b. A Corporation must submit copies of its corporate charter as certified by the Secretary of State.

9. BACKGROUND AND HISTORY.

IMPORTANT: A criminal background check must be performed on the individual applicant(s) in the case of proprietorships and partnerships, and when applicable, 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. The criminal background check shall include previous state(s) of residence, if any. 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. A copy of the criminal background investigation report must be submitted to the appropriate regional licensure office.

You must also attach proof of citizenship or evidence of legal immigration.

The following questions are to be answered about the individual applicant(s) in the case of a proprietorship or partnership, **and** about any responsible person who is hired or appointed by the applicant to be the chief executive officer, director or other person in charge of the overall daily operation of a facility/service. These questions also are to be answered about the members of the governing body (board of directors, etc.) of a corporation, association or other organization applying for license.

a. Has the applicant, or any responsible person referenced above, ever been convicted, or currently under any charges, for offense against the law? (Note: You may exclude traffic violations for which a fine of less than $100.00 was paid, and any offense which was committed before a person's eighteenth birthday and finally adjudicated in a juvenile court or under youth offender law.)

❑ NO ❑ YES If answered yes, give details of person's name, date, place, charge, court, and action taken: _____

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 ❑ .)

11. **FINANCIAL RESOURCES. (Note: This item does not apply to state-operated facilities/services.)** The applicant must show financial solvency and responsibility to operate a facility/service. The applicant must provide a financial statement or other information which is complete and sufficient in showing the total assets, liabilities and income of the applicant. Attach a copy of the most recently proposed budget for the facility's/services' operation, or of the most recent fiscal report or financial statement. The financial statement form included with this application may be used for completing a financial statement. **IMPORTANT: A financial statement must accompany this application.**

12. **DESCRIPTION OF FACILITY/SERVICES.** The licensure rules identify and describe distinct categories of facilities/services, which must meet differing rules, based on the type of program services provided and the needs of the persons served. "Fact Sheet Forms" are included with this application. One (1) fact sheet form must be completed for each distinct category of facility/service to be operated at each site. For example, even if more than one (1) facility/service category is to be operated at a single site, an individual fact sheet must be completed and submitted for each category of facility to be operated at that single site. The enclosed fact sheet forms may be photocopied if additional forms are needed. **IMPORTANT: Fact Sheet Form(s) must accompany this application.**

13. **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, facility programs/services 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.

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

14. **COMMUNITY REFERENCES**. List below the names and addresses of three (3) persons or organizations who can attest to the applicant's responsible and reputable character or reputation, and to the applicant's ability to conduct a facility/service providing services to persons who are vulnerable to neglect, abuse and exploitation. The persons or organizations listed must **not** be related to the applicant by marriage, blood or in a vested business interest. These individuals will be contacted by this department to obtain letters of reference.

a. Name: _____

Address: _____

b. Name: _____

Address: _____

c. Name: _____

Address: _____

15. **ADDITIONAL INFORMATION.** Use this space to provide any additional information you believe would be helpful in determining your application:

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:**

Application Review Checklist:

- ❑ All Required Info. Completed
- ❑ Letters of Reference Returned
- ❑ All Fact Sheet Forms Submitted, if applicable:
- ❑ Criminal Background Check
- ❑ Management Contract (if any) Submitted
- ❑ Evidence of Appropriate Zoning, if applicable
- ❑ Financial Statement Submitted
- ❑ Correct Processing Fee(s) Submitted
- ❑ Governing Board Members Listed
- ❑ Proof of Citizenship or Legal Immigration
- ❑ Evidence (if any) for Deemed Status Determination
- ❑ Corporate Charter Submitted
- ❑ Other Special Investigation or Action Completed: _____

Application Approval Status:

- ❑ Application Approved in Full for All Facilities/Services
- ❑ Application Approved in Part for Following Facilities:
- ❑ Application Denied in Full for Following Reason(s):
- ❑ Application Withdrawn by Applicant.

Licensure Background Check Information

Personal Information	
Social Security Number	
First Name	
Middle Name	
Last Name	
Date of Birth	
Gender	☐ Male ☐ 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?	☐ Yes ☐ 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	☐ Money Order ☐ Credit Card

Vital Information	
Height	
Weight	
Race	☐ WHITE ☐ BLACK ☐ ASIAN/PACIFIC ISLANDER ☐ AMERICAN INDIAN/ALASKAN | ☐ HISPANIC
Hair Color	☐ BALD ☐ BLACK ☐ BLOND ☐ BROWN ☐ GREY ☐ RED ☐ SANDY ☐ WHITE
Eye Color	☐ BLACK ☐ BLUE ☐ BROWN ☐ GREY ☐ GREEN ☐ HAZEL ☐ 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	☐ YES ☐ 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.