**CHANGE OF STATUS**

**INSTRUCTIONS:** Please read carefully and type or print legibly. Use this form to report or request a change in the status of a previously submitted initial application or the conditions of a current license. This form is not for use in changing the ownership or operator of a currently licensed facility or service, the addition of another facility or service by a current licensee, the relocation of a currently licensed facility or service, or a major change in use or occupancy of a currently licensed facility or service. Such changes require new application processes and the prior approval of the Department's Office of Licensure. 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. NAME OF AGENCY OR CURRENT LICENSEE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. DATE OF THIS FORM****:** Month: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. LIST THE NAME(S) OF THE FACILITY OR SERVICE IN WHICH THE CHANGE INDICATED BELOW IS TO OCCUR:**

(Or, check here if change affects all facilities or services:) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4. CHECK THE ITEM BELOW WHICH DESCRIBES THE CHANGE TO OCCUR AND SUPPLY THE REQUESTED INFORMATION:**

|  |  |
| --- | --- |
| * **REQUEST FOR APPROVAL OF CHANGE TO AFFECT CURRENT LIFE SAFETY OCCUPANCY CLASSIFICATION.** A change is being planned in the program of the facility or service listed in item (3) above which will affect the current life safety occupancy classification of the facility as follows:   □ Serving persons who are incapable of self-preservation.  □ Serving persons who use wheelchairs, walkers, etc. for mobility.  □ Imposing security measures upon persons which are beyond their control, (e.g., exit doors or windows locked against egress, restraints, seclusion, etc.)  □ Serving blind persons.  □ Serving deaf persons. | * **CHANGE IN CHIEF EXECUTIVE OFFICER OR DIRECTOR.** The current Licensee has appointed or hired a new person to serve as chief executive officer or director responsible for the overall daily management of the Licensee’s facilities or services as follows:   \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Person’s Name  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Title or Position  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Email Phone Number  A criminal background check must be performed on the individual identified above as the new chief executive officer or director. 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. |
| * **CHANGE IN NAME ONLY OF THE CURRENT LICENSEE.**   The current Licensee is changing in name only from the name listed in item (1) above to the following name:  (This is **not** a change in ownership or operator. The current Licensee is changing in **name only**.) Attach a copy of the legal documentation which evidences this change of name, such as revised corporate charter from Secretary of State, marriage certificate, court papers, etc. | * **REQUEST FOR CHANGE IN CURRENT LICENSED CAPACITY.** The current Licensee is requesting a change in the client or bed capacity number listed on the current License. This capacity change does not involve an expansion or addition to the physical plant of the facility or service. (Such expansion or addition requires the submission of new facility or service fact sheet forms.)   The current capacity is: \_\_\_\_\_ beds/clients.  The requested capacity is for: \_\_\_\_\_ beds/clients.  **NOTE:** Exceeding the licensed client or bed capacity number requires the prior approval of the Department’s Office of Licensure. |
| * **CHANGE IN THE PUBLIC NAME OF THE FACILITY OR SERVICE.** The current Licensee is changing the name of the facility or service listed in item (3) above as it is listed on the current License to the following new name:   **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **NOTE:** Use 1 form for each facility or service name change. | * **NOTICE OF VOLUNTARY CLOSURE OF FACILITY OR SERVICE.** The current Licensee has voluntarily chosen to close the facilities or services listed in item (3) above. The closure will be effective on the following date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Please attach a summary of the reason for the decision to close and the arrangements to be made for displaced clients. |

**OTHER**. Attach a summary to describe any other change or event which affects the status of the application information previously submitted, or the conditions under which the current License was granted. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**5. CERTIFICATION OF INFORMATION.** The person signing below declares his/her authority to submit this information as an addendum or change to the application information supplied to the Department of Intellectual and Developmental Disabilities as a basis for determining issuance of a license. The undersigned person further declares this information to be true, correct and complete to the best of his/her knowledge.

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

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

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

**IMPORTANT NOTICE**: The application and required attachments are to be submitted to the applicable Regional Licensure Office below: The fees must be submitted to the Department’s **Fiscal Services** Office per the address on the “Application Fee Invoice Form”. Proper submission of the application and fees to the **separate addresses** will reduces the time needed to process the application.

**ADDRESSES FOR REGIONAL LICENSURE OFFICES:**

**EAST TENNESSEE** **MIDDLE TENNESSEE WEST TENNESSEE**

Department of Intellectual and Developmental Disabilities Department of Intellectual and Developmental Disabilities Department of Intellectual and Developmental Disabilities

Attn: Licensure Office Attn: Licensure Office Attn: Licensure Office

Alder Building 123 Fir Building Lowell Thomas Building

4850 East Andrew Johnson Highway 309A Stewarts Ferry Pike 225 Dr. Martin Luther King Drive, 4th Floor Tower B

Greeneville, TN 37745 Nashville, TN 37214 Jackson, TN 38301