Tennessee Department of Human Services

Application for a License to Operate an Adult Day Services Agency

Instructions: This application must be completed in full. Attach additional paper as needed. Do not leave any blanks. If you are unsure how to answer a question mark "?", you may contact: . If the question does not apply to you mark "N/A". For any item requiring additional space, please attach additional sheets.

Date Rc'd	
Fee Paid	
Check/MO#	
Receipt #	

(Please type or print)

Identifying Information

	- -		- -
Name of Adult Day Services Agency	FEIN Number	Extension	Phone Number

Agency Street Address	City	State	ZIP
Agency Mailing Address	City	State	ZIP

	- -
Name of Applicant	Phone Number

Applicant Address	City	State	ZIP

		- -	
Driver's License Number	State of DL	Social Security Number	Applicant or Agency Email Address

Business Organization

For all organization types marked with an * you must attach copies of all filings with the office of the Tennessee Secretary of State.

Full Legal Name and d/b/a Name of Business:

Legal Organization (mark only one):

- ☐ Sole Proprietor
- ☐ Partnership
- ☐ Limited Liability Partnership (L.L.P.)*****
- ☐ Public Agency (all or part of the agency is owned or operated by a government entity)

Sponsoring Government Agency		Full name of agency contact person		
				- -
Street Address	City	State	ZIP	Phone Number

☐ Franchise

Parent Corporation Full Name		Full name of corporation contact person		
				- -
Street Address	City	State	ZIP	Phone Number

☐ Corporation (Mark one of the following)

☐ Public Non-Profit

Sponsoring Government Agency		Full name of agency contact person:		
				- -
Street Address	City	State	ZIP	Phone Number

☐ Private Non-Profit*

☐ For Profit*

☐ Limited Liability Corporation*

☐ Other* (describe business organization):

Has the type of legal organization changed since issuance of the last license (for re-application only)? ☐ Yes ☐ No
If yes, state the type of the previous legal organization:

List All Owners (Attach list of additional owners):

Full Name:		Social Security Number: - -	
Street Address	City	State	ZIP
- -	- -	- -	
Work Phone Number	Home Phone Number	Other Phone Number	

List Names, Locations (City/State), and Dates of Services for every adult day services agency the individual has owned, operated, been employed by, or volunteered for:

Names	Locations (City/State)	Dates of Service

List All Members of the Oversight Authority (e.g., Governing Board):

		- -	
Name	Position Title	Work Phone Number	
Street Address	City	State	ZIP

List Names, Locations (City/State), and Dates of Services for every child care agency the individual has owned, operated, been employed by, or volunteered for:

Names	Locations (City/State)	Dates of Service

Attach list of additional members

Initial Application Information

Complete this section if an initial application of Director

Name of Director:							
Education:	☐ GED	☐ High School Diploma	☐College	☐ (Associates)	☐ (Bachelors)	☐ (Masters)	☐Other

Name of School (Attach copy of Diploma/Certificate/Transcript)

School Name	Street Address	City	State	ZIP
Specialized Education related to child care:				

Experience in working in social services, health and/or related field: (List most recent experience first, attach additional sheets of paper if necessary):

		- -	/ / to / /
Employer	Contact Person	Phone Number:	Dates Worked
Street Address	City	State	ZIP

		- -	/ / to / /
Employer	Contact Person	Phone Number:	Dates Worked
Street Address	City	State	ZIP

		- -	/ / to / /
Employer	Contact Person	Phone Number:	Dates Worked
Street Address	City	State	ZIP

		- -	/ / to / /
Employer	Contact Person	Phone Number:	Dates Worked
Street Address	City	State	ZIP

Attach copy of your resume if available

References: (List three (3) who are non-relatives with complete address and daytime telephone numbers)

		- -
Name	Address	Phone Number

		- -
Name	Address	Phone Number

		- -
Name	Address	Phone Number

Program and Services

Who is your target population?
Please describe your program IN DETAIL:

Is your agency accredited? ☐ Yes ☐ No	If yes, accrediting organization:

1. Number and type of meals and snacks to be served:
2. Do you participate in the Child and Adult Care Food Program? ☐ Yes ☐ No
3. Do you ☐ prepare and serve meals,
   ☐ have meals catered, or
   ☐ participants required to bring a sack lunch
4. Please describe the arrangements you have made for food planning/preparation (e.g. food preparation area, cook, consultation with nutritionist) or in food service (e.g. where participants eat, staff support)?

1. Please provide a comprehensive list of services offered to participants and families: (i.e. skilled nursing, physical or occupation therapy, transportation, case management, transportation, off-site activities)
2. List additional fees charged and amount of each, i.e. assessment fee, registration fee, transportation fee, therapy fee.

Service	Fee	Service	Fee	Service	Fee

1. If agency provides transportation, describe transportation plans, procedures and the vehicles utilized in the transportation. Include all vehicle license plate numbers:
2. Do you contract with a third party to provide any programs or services? Example: Transportation; Physical, Occupational, Art or Music Therapy ☐ Yes ☐ No

   If yes, please describe:
3. You must attach a legible copy of all contracts for adult day services programs and services.
   List your rates and rate frequency; full-time, part-time, daily, weekly, monthly, etc.

Rate	Frequency	Rate	Frequency	Rate	Frequency
Rate	Frequency	Rate	Frequency	Rate	Frequency

Days of Operation:	Monday ☐	Tuesday ☐	Wednesday ☐	Thursday ☐	Friday ☐	Saturday ☐	Sunday ☐
Hours of Operation:	am to pm	am to pm	am to pm	am to pm	am to pm	am to pm	am to pm

Holidays:

Do you accept part-time enrollment? ☐ Yes ☐ No

List all funding sources:	Private Pay ☐	Medicaid Waiver ☐	SSBG ☐	Long Term Care Insurance ☐	Other ☐

1. Admission requirements and enrollment procedures:
2. Provision for emergency medical care:

Insurance

Vehicle Liability Insurance:

Name of Company	
Policy Number:	Expiration Date:

General Liability Insurance:

Name of Company	
Policy Number:	Expiration Date:

Have there been any changes in the following areas in the past year?

1. Has agency changed admission policy ☐ Yes ☐ No
2. Has your agency made any changes in family involvement/education activities: ☐ Yes ☐ No
3. Hours of operation ☐ Yes ☐ No
4. Room usage ☐ Yes ☐ No
5. Schedule ☐ Yes ☐ No

6. Program philosophy or policies ☐ Yes ☐ No

7. Program activities ☐ Yes ☐ No

8. Other (explain):

If any item(s) 1-8 marked yes, explain changes made.

Staff Records and Qualifications

Staff Name & Position	Date Started Work	Date Fingerprint Sample Submitted	Training Hours This Licensing Year	Years of Experience	Highest Level of Education	Date of Physical	Date of Staff Orientation	Date of CPR	Date of First Aid	Date of Personnel Evaluation	Date of Work History Verification	Date References Checked

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Staffing Pattern

Use the chart below to describe how the program is staffed. For each hour of the day indicate the number of participants enrolled in the group, the staff members assigned to the group, and the hours worked by each staff members. A group is the number of participants assigned to a staff member or team of staff members occupying an individual room or well-defined space within a larger room. If your program is not organized into self-contained rooms but employs an open space organizational structure and/or allows for a free flow of participants between spaces, please attach clear information about the arrangement of the environment (a floor plan) and how the participants are grouped within it. Clarify how the staffing criteria (adult:participant ratio) are met in this environment. See examples below. Make additional copies as needed for all groups.

STAFFING PATTERN EXAMPLES

AM	NUMBER OF DIRECT CARE STAFF AND PARTICIPANTS EACH HOUR												PM
6:00	7:00	8:00	9:00	10:00	11:00	12:00	1:00	2:00	3:00	4:00	5:00	6:00	7:00
0	1:2	1:8	2:10	2:10	2:10	2:10	2:10	2:9	2:9	1:5	1:5	1:2	
Hours of each staff member **Julie (7:30 – 3:30)** **M. Smith (8:00 – 12:00)** **Marty (12:00 – 6:30)**													

STAFFING PATTERN

AM	NUMBER OF PARTICIPANTS ENROLLED EACH HOUR												PM
6:00	7:00	8:00	9:00	10:00	11:00	12:00	1:00	2:00	3:00	4:00	5:00	6:00	7:00
Hours of each staff member													

Declarations

I affirm that I am the owner or the authorized representative of the owner of the adult day services agency and the information provided is accurate, correct and complete to the best of my knowledge.

I have read and understand the rules by which my agency is to operate, and it is my intent to maintain compliance with them.

I understand that providing false or misleading information may result in the denial of the application or revocation of the current license, and may additionally constitute a Class A misdemeanor, pursuant to the provisions of T.C.A. § 71-3-505(c)(1)(3) and (4).

I understand that *any* change in ownership or in the organization of the business ***automatically terminates*** the adult day services license. I understand that I am required to notify the Tennessee Department of Human Services (TDHS) *before* changing ownership or changing the organization of the adult day services agency.

"I understand that by my signature, I am authorizing TDHS to verify the information supplied in this application. I agree to abide by the licensing standards of the TDHS and the licensing laws (T.C.A. § 71-2-401 et seq.). I understand that the appropriate fee must be submitted to the TDHS when applying for a license to operate an adult day services facility, and is **non-refundable**.

Application Fee

I am applying for an adult day services license to operate the following type agency and agree to submit the indicated annual fee by cashier's check or money order payable to the **Treasurer, State of Tennessee (Adult Day Services license)** Please mail your application and fee to:

Adult Day Services Center			**Adult Day Services Center**			**Adult Day Services Center**		
Five (5) – Nineteen (19) Participants			Twenty (20) – One hundred (100) participants			More than One hundred (100) participants		
☐	Annual Fee	$125	☐	Annual Fee	$200	☐	Annual Fee	$400

Supporting Medicaid Recipients - Agencies wishing to serve Medicaid recipients now or in the future (including any private pay customers who convert to Medicaid) must be determined compliant with all applicable Home and Community-Based Services (HCBS) Settings rules before they can receive Medicaid reimbursement for supporting individuals on Medicaid. More information about the HCBS Settings Rule requirements can be found on the DHS Adult Day Services website-under Resources for Providers.

Please sign below:

Print Name of Individual Completing Form	Title

Signature of Director	Date

Print Name of Owner or Authorized Representative (signature of owner or authorized representative required):	Date

Signature of Owner or Authorized Representative	Date