



**DEPARTMENT OF INTELLECTUAL AND DEVELOPMENTAL  
DISABILITIES  
LONG TERM SUPPORTS EXPANSION REQUEST**

**General Instructions**

Submit the completed application to **Email:** [DIDDProvider.Application@tn.gov](mailto:DIDDProvider.Application@tn.gov)

All questions and correspondence regarding the expansion request should be directed to: **Email:** [DIDDProvider.Application@tn.gov](mailto:DIDDProvider.Application@tn.gov) **or Phone:** (615) 532-6530

Please provide the following information:

Date of Request to Expand: \_\_\_\_\_

\_\_\_\_\_  
Name of Organization

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip Code

\_\_\_\_\_  
Telephone Number Fax Number E-Mail Address

1. **Check the service(s) being requested and identify the region(s) the organization proposes to expand service (s) :**

REQUESTED WAIVER SERVICE (S)	REQUESTED REGION(S)		
	WEST	MIDDLE	EAST
***Support Coordination			
Community-Based Day			
In-Home Day			
Supported Employment Day			
Behavior Respite			
Respite			
*** Intensive Behavioral Residential Services (IBRS)			
Family Model Residential Support			
Medical Residential Services			
Personal Assistance			
Residential Habilitation			
Semi Independent Living ( Self Determination waiver only)			
Supported Living			
Individual Transportation for Personal Assistance and/or Respite			

Date of Request to Expand:

Revised 3/31/15

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Name of Organization

\*\*\*Support Coordination / Transitional Case Management providers may expand to other regions, but are prohibited from providing other waiver services.

\*\*\* Intensive Behavioral Residential Services (IBRS): If the provider is only requesting to add the IBRS waiver service, address only number 5 below and complete and submit your response to the IBRS Provider Application Response Requirements.

\*\*\***For all other requested waiver service(s) in the above table, answer numbers 2- 5**

2. Revised agency supervision plan.
3. Revised organizational chart.
4. Job descriptions for new service(s).
5. Home and Community-Based Services (HCBS) Settings Rule: Date Provider last completed the TN Residential Provider Self-Assessment or the Non-Residential Provider Self-Assessment. If your agency has not submitted an assessment, please complete the appropriate assessment and submit with this application. \_\_\_\_\_

Printed Name of Authorized Representative

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

For DIDD

- QA survey report reviewed. \_\_\_\_\_  
Reviewed: \_\_\_\_\_  
Query of complaints  
Reviewed: \_\_\_\_\_
- Query of investigations  
Reviewed: \_\_\_\_\_
- Regional Office recommendations: \_\_\_\_\_  
Central Office recommendations: \_\_\_\_\_
- TennCare Approval: \_\_\_\_\_

Revised 3/31/15