



State of Tennessee

Health Facilities Commission

665 Mainstream Drive, 2nd Floor, Nashville, TN 37243

www.tn.gov/hfc

Phone: 615-741-7221

June 25, 2024

Sent Via Email

Samantha Powell
The Good Care Helpers
5865 Ridgeway Center Parkway, Suite, 300
Memphis, Tennessee 38120

Facility Type: Home Health Agencies

Dear Administrator:

It is my pleasure to inform you that your application for licensure of The Good Care Helpers located at 5865 Ridgeway Center Parkway, Suite 300, Memphis, Tennessee 38120 has been initially approved Home Health services serving the Pediatric counties in Tennessee: Benton, Carroll, Chester, Crockett, Decatur, Dyer, Fayette, Gibson, Hardeman, Hardin, Haywood, Henry, Lake, Lauderdale, McNairy, Madison, Shelby, Tipton, Weakley and the EEIOCPA counties Fayette, Tipton, and Shelby. Providing services of Skilled Nursing, Speech Therapy, Occupational Therapy, Physical Therapy, Medical Social Services, Home Health Aid Services, and Home Maker Services; effective June 24, 2024. The license number shall be 681. For this initial approval to become final and permanent, your application must be ratified by the Board pursuant to T.C.A. §68-11-206. The Board will consider your application at its next meeting, scheduled for July 31, 2024. **You are hereby authorized to commence operation pending the final decision of the Board.** No further action is necessary on your part currently.

For certification purposes, please be advised it is your responsibility to contact your Health Care Facility's regional office for participation in Medicare/Medicaid. The West Regional Office phone number is 731-984-9684.

If the Board **does** ratify the approval of your application, the license number listed above will become your permanent license number and a letter will be forwarded to you within three (3) business days; notifying you of the Board's final decision.

If the Board **does not** ratify the initial approval of your application, a letter will be forwarded to you providing an explanation and specific instructions as to any action(s) you may take to have the decision reviewed, at which time this authorization shall cease to be effective.

A home health agency limited to the provision of home health services in the federal Energy Employees Occupational Illness Compensation Program Act of 2000 (EEOICPA) and/or to patients under eighteen (18) years of age is required within two (2) years of the initiation of services to obtain accreditation as identified in T.C.A. §68-11-1607(r)(1) & (s)(3). Proof of accreditation must be submitted to the Health Facilities Commission upon receipt.

Please contact me if I can be of further assistance.

Sincerely,

Mary Louise Clark

Mary Louise Clark, ASA II



APPROVAL FOR FACILITY LICENSURE OR OCCUPANCY

Facility Type: HHA License # (if applicable): _____ County: Shelby

Initial X Renovation _____ Satellite/Off Campus Location _____

Physical Plant/Services/New Addition _____ Relocation/Replacement Facility _____
(Circle One) (Circle One)

Facility Name: The Good Care Helpers, LLC

Address: 5865 Ridgeway Center Pkwy, Suite 300 City: Memphis Zip Code: 38120

Application and fee on file in Central Office (CO)? Yes _____ No _____ CON #: _____

Project #: _____ Phase: _____ of _____

Facility approved for (if satellite/off campus site include address): Home Health services serving the following Pediatric counties: Benton, Carroll, Chester, Crockett, Decatur, Dyer, Fayette, Gibson, Hardeman, Hardin, Haywood, Henry, Lake, Lauderdale, McNairy, Madison, Shelby, Tipton, Weakley and the EEIOCPA counties Fayette, Tipton, and Shelby. Providing services of Skilled Nursing, Speech Therapy, Occupational Therapy, Physical Therapy, Medical Social Services, Home Health Aid Services, and Home Maker Services.

Sprinklered: _____ (Full 100%) Partial: _____ (%)

Licensed bed count from: _____ to _____ Number of beds increased/decreased: _____

If secured unit, number of beds in unit: _____ If Alzheimer's unit, number of beds in unit: _____
(NOTE: If this is an increase in the number of beds in a secured Alzheimer's unit, indicate number of beds approved for the increase number only)

Health Surveyor: Candice Rickman Date: 6/18/2024

Fire Safety: _____ Date: _____

CD Approved: Yes _____ No _____ N/A _____ Health Survey Required: Yes _____ No _____

Facility's Letter of Notification received in Licensure: Yes _____ No _____
(Completed by Central Office Licensure Staff)

CMS Paperwork (855, etc) approved and received in regional office: Yes _____ No _____
(NOTE: With exception of Initial Licensure Approvals)

Effective date: _____ Licensure is recommended: Yes X No _____
(Completed by Central Office Licensure Staff)

KZ/Rhonda G. Rogers 6/24/2024



Regional Administrator/Facilities Construction Director or Designee

Date

Licensure Program Unit Staff

Date



State of Tennessee
Health Facilities Commission
665 Mainstream Drive, 2nd Floor, Nashville, TN 37243
www.tn.gov/hfc Phone: 615-741-7221

May 22, 2024

Sent Via Email

Samantha Powell
The Good Care Helpers
5865 Ridgeway Center Parkway, Suite 300
Memphis, Tennessee 38120

Dear The Good Care Helpers:

This is to acknowledge receipt of your application and fee to apply for licensure of The Good Care Helpers. Please review the instruction sheet that you received with the application to apply for licensure so that you are aware of the process for obtaining licensure of your facility. If a certificate of need is required to provide services, you will need to contact *Health Services and Developmental Agency* at (615) 741-2364.

Please remember that if you are applying for licensure of a facility that requires an architectural plans review contact Plans Review for complete and details and procedures at (615) 741-6998. You must submit those plans along with the plans review fee prior to scheduling a survey. **For Homes for the Aged facilities specifically; TCA-368-11-202 allows "schematics shall be submitted to the department for approval of plans and specifications, converting and existing single family dwelling" with six (6) or less beds.**

It is your responsibility to contact the West Tennessee Regional Office to request a survey of your facility. Please submit the request in writing to West Tennessee, Regional Administrator, 295 Summar Drive, Floor 2, Jackson, Tennessee 38301. If you would like to fax the request to Kathy Zeigler) the fax number is 731-427-0407.

Your application and fee will be held in a pending status until you are recommended by the Regional Office for licensure. Once the recommendation for licensure is received from the regional office, your facility will receive a letter for "Initial Approval." Admission of patients MAY NOT occur until the facility's receipt of the "Initial Approval" letter. Your application will be presented before the Board for Licensing Health Care Facilities for ratification and final approval at the next regularly scheduled board meeting. Your facility CAN operate once you receive the "Initial Approval."

This application will only be good for one (1) years from the date of receipt. If the initial licensure has not occurred within that one (1) year period you will be required to submit a new application and fee unless you have contacted our office in writing extending your application.

In the event that a certificate of need is required prior to obtaining a license for this facility the application file will be closed the day following the expiration date of the certificate of need.

A home health agency limited to the provision of home health services in the federal Energy Employees Occupational Illness Compensation Program Act of 2000 (EEOICPA) and/or to patients under eighteen (18) years of age is required within two (2) years of the initiation of services to obtain accreditation as identified in T.C.A. §68-11-1607(r)(1) & (s)(3). Proof of accreditation must be submitted to the Health Facilities Commission upon receipt.

Should you have any questions or if I can be of assistance to you please call me at (615) 741-7202 or you may email me at Mary.2.Clark@tn.gov.

Sincerely,

Mary Louise Clark

Mary Louise Clark, ASA II

3. Geographic area served by Agency: (list county or counties) If additional space is needed, please use a separate page.

N/A

4. Check type of services provided:

a. Skilled Nursing	<u>X</u>	f. Home Health Aid Services	<u>X</u>
b. Physical Therapy	<u>X</u>	g. Medical Supplies and Appliances	<u> </u>
c. Occupational Therapy	<u>X</u>	h. Homemaker Services	<u>X</u>
d. Speech Therapy	<u>X</u>	i. Other (please specify)	<u> </u>
e. Medical Social Services	<u>X</u>		

5. Do you provide services to a pediatric population? Yes X No
If yes, what counties? LAKE, OBION, WEAKLEY, HENRY, BENTON, DYER, GIBSON, LAUDERDALE, CROCKETT, HAYWOOD, CARROLL,
MADISON, HENDERSON, DECATUR, CHESTER, SHELBY, FAYETTE, TIPTON, HARDEMAN, MCNAIRY, HARDIN

6. Is your agency a provider in the EEOICPA federal program? Yes X No

If yes, what counties? SHELBY, TIPTON, FAYETTE

7. Provide proof of the ability to meet the financial needs of the facility.

OWNERSHIP OF BUSINESS:

1. a. Check the type of Legal Entity:

Individual Partnership Corporation Limited Liability Company X

Church Related Government/County Other

- b. Check one: For Profit X Non-profit

- c. Legal Entity checked in 1.a:

Name THE GOOD CARE HELPERS LLC Phone Number (901) 546 4211

Address 5865 RIDGEWAY CENTER PKWY STE 300 MEMPHIS TN 38120

- d. List name(s) and address(es) of individual owners, partners, directors of the corporation, or head of the governmental entity:

SAMANTHA POWELL 1952 S BEND DR CORDOVA TN 38016

Name	Street	City, State, Zip
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Name	Street	City, State, Zip
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(If additional space is needed, please use a separate sheet)

- e. If a government/county owned facility, does the administrator have authority to act on behalf of the government/county as it relates to the operation of this facility? Yes X No

- f. If no to e., who has said authority?

2. a. Is your facility/organization accredited by a federally approved accrediting body including but not limited to JCAHO, CARF, etc.? Provide proof of accreditation.

Yes No X Expiration Date

3. Is this facility chain affiliated? Yes _____ No X

4. If you have a parent company please provide the following information:

Name N/A Phone Number ()

Address N/A

5. a. If a corporation, is there a holding company? Yes _____ No X

b. If yes, list the name, address and phone number of the holding company:

Name N/A Phone Number ()

Street N/A

City N/A State N/A Zip N/A

6. a. Are any owners of the disclosing entity also owners of other health care facilities in Tennessee and/or other states? Yes _____ No X

b. If yes, list names and addresses of all such facilities:

N/A

7. a. Do you have a contract with a management firm to operate this facility? Yes _____ No X

If yes, specify dates: From To

b. If yes, please specify name of firm: N/A

Phone Number ()

Street City, State, Zip

8. a. Have any owners of the disclosing entity ever been denied a license, had a license suspended or revoke, had a suspension of admissions or paid any civil/monitory penalties for a health care facility in Tennessee or in any other state? Yes _____ No X

If yes, where? N/A When?

For what reason?

VERIFICATION BY NOTARY PUBLIC:

Signee for application certifies 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 certifies that a policy has been implemented to inform all employees of their obligation under TCA § 71A-103 to report incidents of abuse or neglect.

[Signature] Director of Health Care Services 5/22/24
Applicant Signature Title or Position Date

STATE OF TENNESSEE

County of Shelby

The above named applicant (print name) Samantha Powell being
by me duly sworn on his/her oath, deposes and says that he/she has read the forgoing application and knows the contents

thereof: that the statements concerning the above named facility or agency, therein contained, are correct and true to his/her own knowledge.

Subscribed to and sworn to on this 22nd day of May 2024
(Month) (Year)



Notary Public Christine Freeman

My commission expires: 08/07/2027

FEE SCHEDULE: (FEES ARE NON-REFUNDABLE) \$1,404



Online Payment Receipt

Receipt Issued By:

Board for Licensing Health Care Facilities

Receipt Issued To:

THE GOOD CARE HELPERS

1952 S Bend dr

Cordova, TN 38016

Date: 05/17/2024

Transaction Identifier: 3874359110

Trace Number: 2002015

License Type	Licensee	Transaction	Application #	Account #	Amount
Home Health Services	THE GOOD CARE HELPERS	Home Health Services: Initial Application	534-12813	*****9891	\$1404.00