



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

July 10, 2024

Sent Via Email

Mark "Erick" Hendrick, Jr.
Trusted Ally Home Care
5299 DTC Boulevard #101
Englewood, Colorado 80111

Facility Type: Home Health Agencies

Dear Administrator:

It is my pleasure to inform you that your application for licensure of Trusted Ally Home Care located at 9047 Executive Park Drive, Suite 226, Knoxville, Tennessee 37923 has been initially approved for Home Health Agency providing Skilled Nursing and Home Health Aid Services and serving the following EEIOCPA of counties: Anderson, Bledsoe, Blount, Bradley, Campbell, Carter, Cheatham, Claiborne, Cocke, Crockett, Cumberland, Davidson, Dickson, Fayette, Fentress Gibson, Greene, Hamlen, Hamilton, Hancock, Hardeman, Hawkins, Haywood, Jefferson, Johnson, Knox, Loudon, McMinn, Madison, Meigs, Monroe, Montgomery, Morgan, Polk, Putnam, Rhea, Roane, Robertson, Rutherford, Scott, Sequatchie, Sevier, Shelby, Sumner, Tipton, Unicoi, Union, Washington, White, Williamson, and Wilson in Tennessee; effective July 9, 2024. The license number shall be 676. 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 29, 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 East Regional Office phone number is 865-594-9396.

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: Home Health Agency License # (if applicable): _____ County: Knox

Initial X Renovation _____ Satellite/Off Campus Location _____
Physical Plant/Services/New Addition _____ Relocation/Replacement Facility _____
(Circle One) (Circle One)

Facility Name: Trusted Ally Home Care

Address: 9047 Executive Park Dr. #226 City: Knoxville Zip Code: 37923

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

Project #: _____ Phase: _____ of _____

Facility approved for (if satellite/off campus site include address): Approved for Home Agency
providing skilled Nursing and Home Health Aid
Services to the following EEOCPA counties: see
attached counties.

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

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

If secured unit, number of beds in unit: NA If Alzheimer's unit, number of beds in unit: NA
(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: Jessika Lilly Date: 7/9/2024

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: 7/9/24 Licensure is recommended: Yes X No _____
(Completed by Central Office Licensure Staff)

Debra Verna by Jessika Lilly 7/9/2024
Regional Administrator/Facilities Construction Director or Designee Date

Mary Louise Clark 7/10/24
Licensure Program Unit Staff Date

Home Health Services Application for Initial Licensure

Attachment

Geographic Area to be Served by Agency

List of Counties:

Knox	Bradley	Shelby
Anderson	Hamilton	Tipton
Roane	Marion	Fayette
Loudon	Sequatchie	Haywood
Blount	Greene	Hardeman
Sevier	Hawkins	Crockett
Jefferson	Hancock	Madison
Cocke	Washington	Gibson
Hamblen	Sullivan	
Grainger	Carter	
Union	Unicoi	
Claiborne	Johnson	
Campbell	Putnam	
Scott	White	
Morgan	Davidson	
Fentress	Wilson	
Cumberland	Rutherford	
Bledsoe	Williamson	
Rhea	Cheatham	
Meigs	Dickson	
McMinn	Montgomery	
Monroe	Robertson	
Polk	Sumner	



State of Tennessee

Health Facilities Commission

665 Mainstream Drive, 2nd Floor, Nashville, TN 37243
www.tn.gov/hsda Phone: 615-741-7221

February 7, 2024

Sent Via Email

Mark "Erick" Hendrick, Jr.
Trusted Ally Home Care
9047 Executive Park Drive, Suite 226
Knoxville, Tennessee 37923

Dear Mark "Erick" Hendrick, Jr.:

This is to acknowledge receipt of your application and fee to apply for licensure of Trusted Ally Home Care. 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 East Tennessee Regional Office to request a survey of your facility. Please submit the request in writing to East Tennessee, Regional Administrator, 7175 Strawberry Plains Pike, Suite 103, Knoxville, Tennessee 37914. If you would like to fax the request to Debra Verna) the fax number is 865-594-5739.

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

1 TSD/East file #674
App # 12712

RECEIVED FEB 05 2024



HOME HEALTH SERVICES APPLICATION FOR INITIAL LICENSURE

All applicable laws, rules, policies, and guidelines affecting your practice are available for viewing at <https://www.tn.gov/hsda/health-care-facilities/hcf-main/licensure.html>. Please check this website periodically for updates.

Name of the Facility/Agency Trusted Ally Home Care

Location of the Facility:

Street 9047 Executive Park Dr Suite 226 City Knoxville

County Knox State TN Zip 37923

Phone Number (865) 839-8801 Fax Number (888) 692-9332

Twenty-four (24) Hour Emergency Phone Number (888) 508-2559

E-Mail Address erick.hendrick@trustedallyhomecare.com

Administrator Information:

Administrator Mark "Erick" Hendrick Jr

Have you (Administrator) ever been convicted of a crime involving injury or harm to person(s), financial or business management (e.g., assault, battery, robbery, embezzlement, fraud)? Yes No x

If yes, what charge(s)? N/A

Location of Conviction N/A (City) (County) (State) Date

Mailing address if different from the Facility location address:

Name Trusted Ally Home Care

Street 5299 DTC Blvd #101

City Greenwood Village State CO Zip 80111

Ownership of Building:

Name All Eleven LLC Phone Number (865) 769-4644

Street 5820 Walden Dr Suite 102

City Knoxville State TN Zip 37919

1. Check type: Hospital Based Nursing Home Based Free Standing x

2. Check type: Licensed only Agency x Licensed/Medicaid Certified

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

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> </u> | g. Medical Supplies and Appliances | <u> </u> |
| c. Occupational Therapy | <u> </u> | h. Homemaker Services | <u> </u> |
| d. Speech Therapy | <u> </u> | i. Other (please specify) | <u> </u> |
| e. Medical Social Services | <u> </u> | | |

5. Do you provide services to a pediatric population? Yes No X

If yes, what counties?

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

If yes, what counties? All Listed

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 TAHC - TN LLC Phone Number (865) 839-8801

Address 116 Agnes Rd Knoxville TN 37919

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

Alexander Page	1099 Green Oaks Dr	Greenwood Village, CO 80121
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Name	Street	City, State, Zip
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Candace Honeywell	1099 Green Oaks Dr	Greenwood Village, CO 80121
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Name	Street	City, State, Zip
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(If additional space is needed, please use a separate sheet)

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 Trusted Ally Home Care, LLC Phone Number (720) 601-1712

Address 5299 DTC Blvd #101 Greenwood Village, CO 80111

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 _____
City _____ State _____ Zip _____
6. a. Are any owners of the disclosing entity also owners of other health care facilities in Tennessee and/or other states? Yes X No _____
b. If yes, list names and addresses of all such facilities:
Trusted Ally Home Care - 1017 E. Basin Ave #5 Pahrump NV 89060
Trusted Ally Home Care - 409 1st St. Grants NM 87020
7. a. Do you have a contract with a management firm to operate this facility? Yes _____ No X
If yes, specify dates: From N/A 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 monetary 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? N/A

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 § 71-6-103 to report incidents of abuse or neglect.

Mark E Hendrick Jr Director of Operations 1/11/2024
Applicant Signature Title or Position Date

STATE OF TENNESSEE

County of _____

The above named applicant (print name) Mark E Hendrick Jr., 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 11th day of January 2024
(Month) (Year)

Notary Public: Daphne Toney

My commission expires: 09/28/2027



Tennessee Department of Health
Cash Listing Report

Client: 343 - DEPARTMENT OF HEALTH		Origin: Deposit		Fiscal Year: 2024						
Batch #: 115	Total \$ Entered: \$ 1,404.00	Deposit #: 02052024		Deposit Date: 2024-02-06						
# Receipt: 1	Receipts Entered: 1	Total: \$ 1,404.00		Status: Deposited						
Receipt #	DLN	Received Disp	Pmt	Bad Check?	Unassigned	Prof	Remitted By / Beneficiary	File #	License #	Assigned
1043	37057001	\$ 1,404.00	DEP	CHK	\$ 1,404.00	534	TRUSTED ALLY HOME CARE	676		
Total:		\$ 1,404.00		\$ 1,404.00						

STATE OF TENNESSEE
Health Services and Dev Agency
Office: Andrew Jackson, 8t
2/5/2024 2:17 PM
Cashier: MARYL1011002
Batch #: 1575967
Trans #: 2
Healin Care Facilities
#: 37057001
ICF
Total: \$1,404.00
Transaction Total: \$1,404.00
Check 21
Thank you for your payment.
Have a nice day!