



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

August 12, 2024

Sent Via Email

Nicole McCamey
Huntsville Hospital Home Medical Equipment
900 Bob Wallace Avenue, SW Suite #118
Huntsville, Alabama 35801

Facility Type: Home Medical Equipment

Dear Nicole McCamey:

It is my pleasure to inform you that your application for Huntsville Hospital Home Medical Equipment has been initially approved for providing Home Medical Equipment services in all counties in Tennessee; effective August 5, 2024. The license number shall be 1442. For this initial approval to become final and permanent, your application must be ratified by the commission pursuant to T.C.A. §68-11-206. The Commission will consider your application at its next meeting, scheduled for August 2024. **You are hereby authorized to commence operation pending the final decision of the Commission** No further action is necessary on your part currently.

For certification purposes, please be advised it is your responsibility to contact your Health Facilities Commission regional office for participation in Medicare/Medicaid. The East Tennessee Regional Office phone number is 865-594-9396 .

If the Commission **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 Commission final decision.

If the Commission **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.

Please contact me if I can be of further assistance.

Sincerely,

Niraj Soni

Niraj Soni, ASA 3
Phone: (615) 741-7539
Fax: (615) 253-8798
Email: Niraj.Soni@tn.gov

cc: East Tennessee Regional Administrator



APPROVAL FOR FACILITY LICENSURE OR OCCUPANCY

Facility Type: HME License # (if applicable): _____ County: _____

Initial X Renovation _____ Satellite/Off Campus Location _____

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

Facility Name: Huntsville Hospital Home Medical Equipment

Address: 900 Bob Wallace Avenue SW, Suite 118 City: Huntsville AL
Zip Code: 35801

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): To provide Home Medical Equipment services to all counties in Tennessee. _____

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: Rebecca K. Anderson Date: 7-11-2024

Fire Safety: _____ Date: _____

CD Approved: Yes _____ No _____ N/A _____ Health Survey Required: Yes X 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: August 5, 2024
(Completed by Central Office Licensure Staff)

Licensure is recommended: Yes X No _____

Debra Verna JR 8/5/2024
Regional Administrator/Facilities Construction Director or Designee Date
Niraj Sen 08/12/24
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

April 1, 2024

Sent Via Email

Nicole McCamey
Huntsville Hospital Home Medical Equipment
900 Bob Wallace Avenue, SW, Suite. 118
Huntsville, Alabama 35801

Dear Huntsville Hospital Home Medical Equipment:

This is to acknowledge receipt of your application and fee to apply for licensure of Huntsville Hospital Home Medical Equipment. 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.

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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,

Office of Health Care Facilities
Licensure Section

ACKNLINT



ITSD/East App #23072
File #1442

RECEIVED APR 01 2024

HOME MEDICAL EQUIPMENT

APPLICATION FOR INITIAL LICENSURE

All applicable laws, rules, policies, and guidelines affecting your practice are available for viewing at <https://www.tn.gov/hfc/division-of-licensure-and-regulation/hfc-licensure/licensure-applications.html>. Please check this website periodically for updates.

Name of the Facility/Agency Huntsville Hospital Home Medical Equipment

Location of the Facility:

Street 900 Bob Wallace Ave. SW, Ste. 118

City Huntsville

County Madison

State AL

Zip 35801

Phone Number (256) 883-0505

Fax Number (256) 883-0046

Twenty-four (24) Hour Emergency Phone Number (256) 883-0505 (answering service for after hours RT services only)

Business Customer Service Phone Number with twenty-four (24) hour access/seven (7) days a week (800) 423-8677

E-Mail Address nmccamey@medsouthinc.net

Does your facility have a physical location in the state of Tennessee? Yes _____ No X

Administrator Information:

Administrator Nicole McCamey (Branch Manager)

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, or fraud)? Yes _____ No X

If yes, what charge(s)? NA

Location of Conviction NA
(City)

(County)

(State)

Date _____

Mailing address if different from the Facility location address:

Name Huntsville Hospital Home Medical Equipment

Street 406 Medical Center Dr.

City Jasper

State AL

Zip 35501

Ownership of Building:

Name CVP Partners, LLC

Phone Number (636) 227-3200

Street P. O. Box 12203

City Huntsville

State AL

Zip 35815

1. Are you a provider providing manufactured or distributing company-branded Insulin Infusion Pumps and related supplies? Yes _____ No X (If so, the following are requirements, which must be met).
- a. Do you have an employee presence within the state of Tennessee? Yes _____ No X
(Please describe the nature of the employee's physical presence in the state) _____
- b. Provide Joint Commission Accreditation (JCAHO). (Please provide JCAHO letter and complete report in accordance with T.C.A. TCA 68-11-226(e)) _____
2. Geographic area served by Agency: (list county or counties) If additional space is needed, please use a separate page.
All counties _____
3. Number of branch offices: None
Address of each branch office: (If additional space is needed, please use a separate page) _____
4. **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 X Limited Liability Company
____ Church Related _____ Government/County _____ Other
- b. Check one: For Profit X Non-profit _____
- c. Legal Entity checked in 1.a:
Name HGA Home Medical Equipment, LLC Phone Number (205) 221-8200
Street 406 Medical Center Dr.
City Jasper State AL Zip 35501
- d. List name(s) and address(es) of individual owners, partners, directors of the corporation, or head of the governmental entity:
- | | | |
|--|-------------------|------------------------|
| James D. Warren, President/CEO | 5189 Bay Drive | Orange Beach, AL 36561 |
| Name | Street | City, State, Zip |
| Gregory C. Duckworth, Sr. Vice-President | 883 Brookline Rd. | Gardendale, AL 35071 |
| Name | Street | City, State, Zip |
| See attached for additional individuals | | |
| Name | Street | City, State, Zip |
- (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 _____ No _____ NA

- f. If no to e., who has said authority? NA
2. a. Is your facility/organization accredited by a **federally approved** accrediting body but not limited to JCAHO, CARF, etc.? **Provide proof of accreditation.**
Yes The Joint Commission No Expiration Date 03/26/2025
3. If you have a parent company, please provide the following information:
Name Med-South, Inc. (Joint Owner) Phone Number (205) 221-8200
Address 406 Medical Center Dr., Jasper, AL 35501
#2. The Health Care Authority of North Alabama (Joint Owner); (256) 265-9436; 801 Clinton Ave. E., Huntsville, AL 35801
4. 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 NA Phone Number ()
Street
City State Zip
5. a. Are any owners of the disclosing entity or 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:
See attached
6. a. Do you have a contract with a management firm to operate this facility? Yes No X
If yes, specify dates: From NA To
b. If yes, please specify name of firm: NA
Phone Number () NA
NA
Street City, State, Zip
7. 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
b. If yes, where? NA When?
c. For what reason? NA

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.

☐ By checking this box, you acknowledge that you will ensure access to a secure online portal is available to Health Facilities Commission surveyors in order to conduct all necessary and required surveys related to licensure.

Lisa Wells
Applicant Signature

VP
Title or Position

3/10/24
Date

STATE OF ~~TENNESSEE~~ ALABAMA

County of Walker

The above named applicant (print name) Lisa Wells, 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 18th day of March 2024
(Month) (Year)

Notary Public: Sarah Newell

My commission expires: My Commission Expires June 17, 2024.

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