



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

Yuvone Martinez
Doctor's Medical, LLC
497 State Road 436, Suite # 155
Casselberry, Florida 32707

Facility Type: Home Medical Equipment

Dear Yvonne Martinez:

It is my pleasure to inform you that your application for Doctor's Medical, LLC has been initially approved for providing Home Medical Equipment services in all counties in Tennessee; effective July 29, 2024. The license number shall be 1455. 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 West Tennessee Regional Office phone number is 731-984-9684 .

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): #1455 County: Out of State Provider

Initial X Renovation _____ Satellite/Off Campus Location _____

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

Facility Name: Doctors Medical, LLC

Address: 497 State Road 436, Suite 155 City: Casselberry, FL Zip Code: 32707

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): Out of State Home Medical Equipment
Provider serving 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: Celia Skelley RN PHNCI Date: 7/29/24

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 X
(NOTE: With exception of Initial Licensure Approvals)

Effective date: Aug July 29, 2024 Licensure is recommended: Yes X No _____
(Completed by Central Office Licensure Staff)

Kathy Zeigler, RA/DPM 7/29/2024

Regional Administrator/Facilities Construction Director or Designee

Niraj Sen
Licensure Program Unit Staff

Date
8/12/24
Date



State of Tennessee

Health Facilities Commission

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

www.tn.gov/hfc

Phone: 615-741-7221

May 30, 2024

Sent Via Email

Doctors Medical, LLC
497 State Road 436, Suite 155
Casselberry, Florida 32707

Dear Doctors Medical, LLC:

This is to acknowledge receipt of your application and fee to apply for licensure of Doctors Medical, LLC. 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.

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

F-1455
WTRO/FTSD

Reviewed
8/12/24



HOME MEDICAL EQUIPMENT

APPLICATION FOR INITIAL LICENSURE

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

Name of the Facility/Agency Doctors Medical, LLC

Location of the Facility:

Street 497 State Road 436 Suite 155 City Casselberry

County Seminole State Florida Zip 32707

Phone Number (407) 971-8708 Fax Number (407) 641-8828

Twenty-four (24) Hour Emergency Phone Number (407) 921-9335

Business Customer Service Phone Number with twenty-four (24) hour access/seven (7) days a week (407) 921-9335

E-Mail Address Credentialing@drsmedical.com

Does your facility have a physical location in the state of Tennessee? Yes ☐ No ☒

Administrator Information:

Administrator Yvonne Martinez

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 ☒

If yes, what charge(s)? _____

Location of Conviction _____ Date _____
(City) (County) (State)

Mailing address if different from the Facility location address:

Name Same as Facility Location

Street _____

City _____ State _____ Zip _____

Ownership of Building:

Name PAW Holdings, LLC (Vincent Wolle) Phone Number (407) 647-0200

Street 108 Commerce Street, Suite 200

City Lake Mary State Florida Zip 32746

1. Geographic area served by Agency: (list county or counties) If additional space is needed, please use a separate page
Located out of state. Our facility will serve all of the state of Tennessee

2. Number of branch offices: 1

Address of each branch office: (If additional space is needed, please use a separate page)
497 State Road 436, Suite 155 Casselberry, Florida 32707

3. **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
Church Related Government/County Other

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

- c. Legal Entity checked in 1.a:

Name Doctors Medical, LLC Phone Number (407) 971-8708
Street 497 State Road 436 Suite 155
City Casselberry State Florida Zip 32707

- d. List name(s) and address(es) of individual owners, partners, directors of the corporation, or head of the governmental entity: Brett West 2909 Seasons Blvd, Sarasota, FL 34240

Thomas Mollick 10325 Happy Hollow Ave, Odessa, FL 33556
Name Thomas Mollick Street 10325 Happy Hollow Ave City, State, Zip Odessa, FL 33556

David Rocco 4967 Courtland Loop, Winter Springs, FL 32708
Name David Rocco Street 4967 Courtland Loop City, State, Zip Winter Springs, FL 32708

Travis Irwin 363 39th Ave St.Pete Beach, FL 34240
Name Travis Irwin Street 363 39th Ave City, State, Zip St.Pete Beach, FL 34240

(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

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

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 ☒ No Expiration Date 6/30/2025

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

d. Termination/Suspension

i) suspended or terminated from participation in Medicare or Medicaid/TennCare programs? Yes _____ No X

(Note: This would include involuntary termination of a nursing facility or skilled nursing facility by the Centers for Medicare and Medicaid Services (CMS) or state Medicaid agency).

e. Fraud and Abuse

i) paid through settlement, or civil or criminal fines, any monies to the federal government or any state as a result of any administrative or judicial proceeding based on allegations of fraud or abuse involving claims related to the provision of health care items and services? Yes _____ No X

f. Corporate Integrity Agreement

i) Is presently an entity covered by and subject the terms of a corporate integrity agreement? Yes _____ No X

(Note: If yes, provide a copy of CIA)

g. Bankruptcy

i) filed bankruptcy under any provision of the United States Bankruptcy Code? Yes _____ No X

h. Civil Monetary Penalty (CMP)

i) paid to the Centers for Medicare and Medicaid Services or any state Medicaid agency a civil money penalty equal to or greater than \$250,000.00 as a result of an enforcement action during a survey? Yes _____ No X

Failure to provide true and correct copies of any documents related to the items list in 7(a-h) listed above may be grounds for referral of the application for special consideration, and/or may be grounds for disciplines.

If the applicant answered "Yes" to any of the questions (a)-(h) above, please provide copies of any documentation associated with the event and/or sanction. The documentation should provide the Health Facilities Commission with sufficient information regarding the nature of the event and/or sanction, the current status of the issue, as well as details regarding what corrective action have been implemented (as applicable).

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.

Applicant Signature

Title or Position

Date

Credentiaing manager

8/12/24

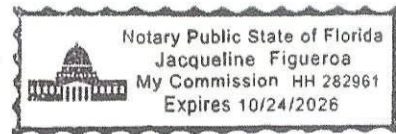
STATE OF TENNESSEE

County of Seminole

The above named applicant (print name) Yvonne Martin, 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.

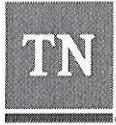
Subscribed to and sworn to on this 12 day of August 2024
(Month) (Year)

Notary Public: Jacqueline Figuera



My commission expires: _____

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



Department of
Health

Online Payment Receipt

Receipt Issued By:

Board for Licensing Health Care Facilities

Receipt Issued To:

Doctors Medical, LLC
4967 Courtland Loop
Winter Springs, FL 32708

Date: 05/28/2024

Transaction Identifier: 3874914601

Trace Number: 2010749

License Type	Licensee	Transaction	Application #	Account #	Amount
Home Medical Equipment	Doctors Medical, LLC	Home Medical Equipment: Initial Application	548-23130	*****3015	\$1404.00