

Application Summary

9/8/25 8:09 AM

APP #23666
File # 1535
WTRO/ITSD

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Application Detail

License Type: **Home Medical Equipment: Licensed**

Application: **Home Medical Equipment: Initial Application**

Application Date: **09/08/2025 (mm/dd/yyyy)**

Organization Detail

Organization Name: **National Seating & Mobility, Inc.**
Organization Type: **Corporation**

Addresses

Main Address

Address: **111 Old Hickory Blvd. E**
Suite A
MADISON
Jackson, TN
38305-4534
US

Phone Number: **731-574-2714**

Extension:

E-mail Address: **Jacksontn@nsm-seating.com**

Administrative

Name: **National Seating & Mobility, Inc.**

Address: **5959 Shallowford Rd.**

Suite 443

HAMILTON

Chattanooga, TN

37421-2245

US

Phone Number: **423-756-2268**

Extension:

E-mail Address:

nsmeast@nsm-seating.com

Emergency Contact

Name:

National Seating & Mobility

Address:

111 Old Hickory Blvd. E

Suite A

MADISON

Jackson, TN

38305-4534 Corporation

US

Phone Number:

731-574-2714

Extension:

E-mail Address:

jacksontn@nsm-seating.com

Ownership of Building

Name:

Susan A Cox

Address:

2768 North Highland Ave

MADISON

Jackson, TN

38305

US

Phone Number:

731-660-2391

Extension:

E-mail Address:

scox@susancoxdevelopment.com

Legal Entity

Name:

National Seating & Mobility, Inc.

Address:

5959 Shallowford Rd.

Suite 443

HAMILTON

Chattanooga, TN

37421-2245**US**

Phone Number:

423-756-2268

Extension:

E-mail Address:

nsmeast@nsm-seating.com

License Attributes Selected

Qualification/Certification

Benton**Carroll****Chester****Crockett****Decatur****Dickson****Dyer****Fayette****Gibson****Hardeman****Hardin****Haywood****Henderson****Henry****Lake****Lauderdale****Madison****McNairy****Obion****Perry****Shelby**

Tipton**Wayne****Weakley**

Additional License Information

For Profit**Basic License Data**

If your facility has branch offices provide the number. If none, enter 00	↑ 00 (NS)
Provide Administrator's Name:	Debra Blackwell
Provide the Ownership's Name:	National Seating &
Ownership Name Continued:	Mobility, Inc.
Is your facility accredited by a federally approved accrediting body?	Yes
If answered yes accredited, must provide expiration date of accreditation.	02/26/2026 (mm/dd/yyyy) 02/26/2028 (NS)
What type of Home Care Organization: Hospital Based or Nursing Home Based or Free Standing?	Free Standing
Provide a Yes or No, if your facility is Chain Affiliated:	No
Provide a Yes or No, if your facility has a Holding Company:	No
Do you have Other Licensed Facilities in the state of Tennessee and/or other states?	Yes
Provide a Yes or No, if your facility has a parent company:	Yes
Do you have a contract with a management firm to operate this facility?	No
Have any owners 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?	No
Does your facility have a physical location in Tennessee?:	Yes

Administrator Conviction Information

Administrator convicted of crime?: **No**

Individual Owners, Partners, Director or Head of Government Entity

The name of the individual owner, partner, director of the corporation or head of the government: **WCM NSM Acquisition Corporation**

Street: **5959 Shallowford Rd., Suite 443**

City: **Chattanooga**

State: **Tennessee**

Zip: **37421-2245** Please see attached !

Owner Discipline Information

Have any of the owners of the disclosing entity ever been denied a license suspended or revoked?: **No**

Have any of owners of the disclosing entity had a suspension of admissions?: **No**

Have any of the owners of the disclosing entity paid any civil monetary penalties for a health care facility in Tennessee or any other state?: **No**

File Attachments

BR 285 TN Sales and Use Tax License.pdf

Fees

Initial License Fee **\$1404.00**

Total Amount Due: **\$1404.00**

Attestation

I, being duly sworn and identified as the person referred to in this application attest to the truth of each statement made in said application. I further swear that I have read and understand the law and the Rules and Regulations regarding the practice of my profession, which are posted on the Board's Internet site and/or were provided to me by the Board office, and agree to abide by them in the practice as a Home Medical Equipment facility in the State of Tennessee. I HEREBY: SIGNIFY my willingness to appear to answer such questions as the Board may find necessary, which may include a full Board interview. RELEASE to the Board, its staff, and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice as a Home Medical Equipment facility. AUTHORIZE the Board, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications. RELEASE from liability the Board, its staff, and all their representatives and any

and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character, and/or other qualifications, for certification. ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, and other qualifications, and for resolving any doubts about such qualifications. AUTHORIZE release, use and disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary. This certifies that the information submitted by me in this application is true and complete to the best of my knowledge and belief.



State of Tennessee
Health Facilities Commission
Andrew Jackson State Building
502 Deaderick Street, 9th Floor, Nashville, TN 37243
www.tn.gov/hfc Phone: 615-741-7221

April 8, 2026

Sent Via Email

Debra Blackwell
National Seating & Mobility, Inc.
111 Old Hickory Blvd. E. Suite A
Jackson, Tennessee 38305

Facility Type: Home Medical Equipment

Dear Debra Blackwell:

It is my pleasure to inform you that your application for licensure of National Seating & Mobility, Inc. located at 111 Old Hickory Blvd. E, Jackson, Tennessee 38305-4534 has been initially approved for Initial HME providing the following counties in Tennessee are Benton, Carroll, Chester, Crockett, Decatur, Dickson, Dyer, Fayette, Gibson, Hardeman, Hardin, Haywood, Henderson, Henry, Lake, Lauderdale, Madison, McNairy, Obion, Perry, Shelby, Tipton, Wayne, and Weakley effective April 8, 2026. The license number shall be 1535. 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 May 27, 2026. **You are hereby authorized to commence operation pending the final decision of the Commission.**

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's 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



APPROVAL FOR FACILITY LICENSURE OR OCCUPANCY

Facility Type: HOME MEDICAL EQUIPMENT License # (if applicable): 1535 County: MADISON
Initial Renovation _____ Satellite/Off Campus Location _____
Physical Plant/Services/New Addition _____ Relocation/Replacement Facility _____
(Circle One) (Circle One)

Facility Name: NATIONAL SEATING and MOBILITY, Inc

Address: 111 OLD HICKORY BLVD E, SUITE A City: JACKSON Zip Code: 38305

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): Initial licensure HME Approved for the following counties: Benton, Carroll, Chester, Crockett, Decatur, Dickson, Dyer, Fayette, Gibson, Hardeman, Hardin, Haywood, Henderson, Henry, Lake, Lauderdale, Madsion, McNairy, Obion, Perry, Shelby, Tipton, Wayne, Weakley

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, QUINTEN HODGE *CSH* Date: 3/11/2026

Fire Safety: _____ Date: _____

CD Approved: Yes _____ No _____ N/A Health Survey Required: Yes No _____; if Yes, please indicate which region: West TN

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 _____ NA
(NOTE: With exception of Initial Licensure Approvals)

Effective date: April 8, 2026 Licensure is recommended: Yes No _____
(Completed by Central Office Licensure Staff)

Donald Hale, Acc Supervisor, 3/10/26
Regional Administrator/Facilities Construction Director or Designee Date
Niraj Soni 4/8/2026
Licensure Program Unit Staff Date



March 14, 2025

Crispin Teufel
Chief Executive Officer
National Seating & Mobility, Inc.
5959 Shallowford Road, Suite 443
Chattanooga, TN 37421

Joint Commission ID #:434450
Program: Home Care Accreditation
Accreditation Activity: 60-day Evidence of Standards
Compliance
Accreditation Activity Completed : 3/13/2025

Dear Mr. Teufel:

The Joint Commission is pleased to grant your organization an accreditation decision of Accredited for all services surveyed under the applicable manual noted below:

Comprehensive Accreditation Manual for Home Care

This accreditation cycle is effective beginning February 26, 2025 and is customarily valid for up to 36 months. Please note, The Joint Commission reserves the right to shorten the duration of the cycle.

Should you wish to promote your accreditation decision, please view the information listed under the 'Publicity Kit' link located on your secure extranet site, The Joint Commission Connect.

The Joint Commission will update your accreditation decision on the Find Accredited Organizations page of our website.

Congratulations on your achievement.

Sincerely,

A handwritten signature in black ink, appearing to read "Ken Grubbs".

Ken Grubbs, DNP, MBA, RN
Executive Vice President and Chief Nursing Officer
Division of Accreditation and Certification Operations