



REcieved revised 4/8/2026  
APP# 23642  
F-1530  
WTRO/ITSD

## 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 Neuroolutions Inc

#### **Location of the Facility:**

Street 7033 Hayvenhurst Ave City Van Nuys

County Los Angeles State CA Zip 91406

Phone Number ( 831 ) 295 6139 Fax Number ( 323. ) 300 2410

Twenty-four (24) Hour Emergency Phone Number (      ) ~~NA~~ (NA)

Business Customer Service Phone Number with twenty-four (24) hour access/seven (7) days a week ( 831 295 6139 )

E-Mail Address alex@neuroolutions.com , Leo@neuroolutions.com

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

#### **Administrator Information:**

Administrator Leo Petrossian

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)?     

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

#### **Mailing address if different from the Facility location address:**

Name Same

Street     

City      State      Zip     

#### **Ownership of Building:**

Name Leo Petrossian Phone Number ( 818 ) 317-4999

Street 7033 Hayvenhurst Ave

City Van Nuys State CA Zip 91406

1. Geographic area served by Agency: (list county or counties) *If additional space is needed, please use a separate page.*  
All . Home Medical Device

Out of State California , All Counties of Tennessee (NS)

2. Number of branch offices: ~~4~~ 00 (NS)

Address of each branch office: *(If additional space is needed, please use a separate page)*

N/A

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   X   Corporation      Limited Liability Company

     Church Related      Government/County      Other

b. Check one: For Profit      Non-profit

c. Legal Entity checked in 1.a:

Name Neuroolutions, Inc Phone Number (831 )295-6139

Street 7033 Hayvenhurst Ave

City Van Nuys State CA Zip 91406

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

(Attached)

Name \_\_\_\_\_ Street \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Name \_\_\_\_\_ Street \_\_\_\_\_ City, State, Zip \_\_\_\_\_

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   X  

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

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   X   No      Expiration Date ~~March, 20, 2020~~ 06/04/2026 (NS)

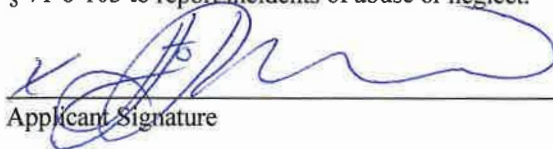
3. If you have a parent company, please provide the following information:

2. a. Is your facility/organization accredited by a **federally approved** accrediting body but not limited to JCAHO, CARF, etc.? Yes  No  Expiration Date \_\_\_\_\_
- b. Is your facility/organization deemed by a **federally approved** accrediting body but not limited to JCAHO, CARF, etc.? Yes  No  Expiration Date \_\_\_\_\_
3. If you have a parent company please provide the following information:  
 Name \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_  
 Address \_\_\_\_\_
4. a. Are any owners of the disclosing entity or also owners of other health care facilities in Tennessee and/or other states? Yes  No
- b. If yes, list names and addresses of all such facilities:  
 \_\_\_\_\_  
 \_\_\_\_\_
5. a. Do you have a contract with a management firm to operate this facility? Yes  No   
 If yes, specify dates: From \_\_\_\_\_ To \_\_\_\_\_
- b. If yes, please specify name of firm: \_\_\_\_\_  
 Phone Number (\_\_\_\_) \_\_\_\_\_  
 \_\_\_\_\_  
 Street \_\_\_\_\_ City, State, Zip \_\_\_\_\_
6. 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
- b. If yes, where? \_\_\_\_\_ When? \_\_\_\_\_
- c. 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 § 71-6-103 to report incidents of abuse or neglect.

 \_\_\_\_\_ Title or Position CEO Date 8/7/2025

Division of Health Licensure and Regulations, Office of Health Facilities Program, 665 Mainstream Drive, Second Floor, Nashville, TN 37228-1254

**d. Termination/Suspension**

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

*(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 \_\_\_

**f. Corporate Integrity Agreement**

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

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

**g. Bankruptcy**

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

**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 \_\_\_

***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).***

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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

\_\_\_\_\_  
Chief Executive Officer  
Title or Position

\_\_\_\_\_  
8.8.2025  
Date

Calif. JT

STATE OF TENNESSEE

County of Los Angeles

The above named applicant (print name) Leo Petrossian, 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 7 day of August 2025  
(Month) (Year)

Notary Public: [Signature]

My commission expires: 9-16-26



**SEE ATTACHED ACKNOWLEDGMENT PAGE**  
➔

# ACKNOWLEDGMENT

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California  
County of Los Angeles )

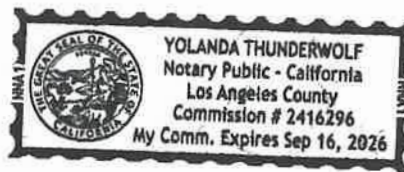
On Aug. 7, 2025 before me, Yolanda Thunderwolf, Notary Public  
(insert name and title of the officer)

personally appeared Leo Petrossian  
who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature  (Seal)





State of Tennessee  
Health Facilities Commission  
Andrew Jackson State Building  
502 Deaderick Street, 9<sup>th</sup> Floor, Nashville, TN 37243  
[www.tn.gov/hfc](http://www.tn.gov/hfc) Phone: 615-741-7221

April 8, 2026

Sent Via Email

Leo Petrossi  
Neuroolutions, Inc  
7033 Hayvenhurst Ave  
Van Nuys, California 91406

Facility Type: Home Medical Equipment

Dear Leo Petrossi:

It is my pleasure to inform you that your application for licensure of Neuroolutions Inc located at 7033 Hayvenhurst Ave, Van Nuys, California 91406 has been initially approved for Out of State Home Medical Equipment Provider serving all counties in Tennessee effective April 8, 2026 . The license number shall be 1530 . 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](mailto:Niraj.Soni@tn.gov)



**APPROVAL FOR FACILITY LICENSURE OR OCCUPANCY**

Facility Type: HME License # (if applicable): ##1530 County: Out of State HME Provider

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

Facility Name: Neuroolutions Inc.

Address: 7033 Hayvenhurst Ave. City: Van Nuys, CA ZIP Code: 91406

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): 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 *CS* Date: 3/30/26

Fire Safety: \_\_\_\_\_ Date: \_\_\_\_\_

CD Approved: Yes \_\_\_\_\_ No \_\_\_\_\_ N/A  Health Survey Required: Yes  No \_\_\_\_\_  
Region WTN

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)

*KZ/Rhonda Rogers* 4/2/2026  
Regional Administrator/Facilities Construction Director or Designee Date

*Niraj Soni* 4/8/2026  
Licensure Program Unit Staff Date

Administrator is Leo Petrossian: [Leo@neuroolutions.com](mailto:Leo@neuroolutions.com)  
Please send copy to Alex Hamza: [Alex@neuroolutions.com](mailto:Alex@neuroolutions.com)



FOR PROVIDERS.  
BY PROVIDERS.

March 6, 2026

Neuroolutions, Inc  
Alex Hamza  
7033 Hayvenhurst Ave  
Van Nuys, CA 91406

Dear Alex Hamza:

Thank you for submitting your Accreditation Application packet. Accreditation Commission for Health Care (ACHC) has received the following items:

- Accreditation Application
- Deposit
- Signed and returned Accreditation Agreement
- Preliminary Evidence Report Checklist with required documents

As of the date of this letter, Neuroolutions, Inc is officially *In Process* with ACHC to obtain an accreditation survey for the DMEPOS Program(s). As requested, this serves as notification. Your in-process status is in effect for a period of 180 days and will expire on June 4<sup>th</sup>, 2026.

If you have any questions about your Accreditation Application or the accreditation process, feel free to contact your Account Advisor:

Korishia Taylor  
(919) 785-1214 ext. 348  
ktaylor@achc.org

Sincerely,

Deborah Panza, BS, RRT, RPSGT  
Associate Program Director