

## Application Summary

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### Application Detail

License Type: Home Medical Equipment: Licensed  
Application: Home Medical Equipment: Initial Application  
Application Date: 02/03/2026 (mm/dd/yyyy)

### Organization Detail

Organization Name: Smart Choice Medical, LLC dba Almed (CNS)  
Organization type: Limited Liability Company CNS

### Addresses

#### Main Address

Address: 148 Market Place Blvd

KNOX

Knoxville, TN

37922

US

Phone Number:

~~800-876-6855~~ 203-309-3785 (CNS)

Extension:

E-mail Address:

accounting@hfmed.us

#### Administrative

Name:

Smart Choice Medical, LLC dba Almed (CNS)

Address:

148 Market Place Blvd

KNOX

Knoxville, TN

37922

US

Phone Number:

~~800-876-6855~~ 203-309-3785 (CNS)

Extension:

E-mail Address:

accounting@hfmed.us

#### Emergency Contact

Name:

Smart Choice Medical, LLC dba AI Med (NS)

Address:

148 Market Place Blvd

KNOX

Knoxville, TN

37922

US

Phone Number:

~~800-876-6855~~ 203-309-3785

Extension:

E-mail Address:

accounting@hfmed.us

**Ownership of Building**

Name:

The Terraces Office Park, LLC

Address:

PO Box 31408

KNOX

Knoxville, TN

37930

US

Phone Number:

865-251-1203

Extension:

E-mail Address:

CPManagementoffice@gmail.com

**Legal Entity**

Name:

Smart Choice Medical, LLC, dba AI Med

Address:

148 Market Place Blvd (NS)

KNOX

Knoxville, TN

37922

US

Phone Number:

~~800-876-6855~~  
203-309-3785 (NS)

Extension:

E-mail Address:

accounting@hfmed.us

**License Attributes Selected**

Qualification/Certification **All Counties**

Additional License Information **For Profit**

**Basic License Data**

If your facility has branch offices provide the number. If none, enter 00 **00**

Provide Administrator's Name: **Martha Glasscock**

Provide the Ownership's Name: ~~H&F Medical, LLC~~ **Smart Choice Medical, LLC**  
*dba Al med CNS*

Is your facility accredited by a federally approved accrediting body? **Yes**

If answered yes accredited, must provide expiration date of accreditation. **04/04/2028 (mm/dd/yyyy)**

What type of Home Care Organization: **Free Standing**  
Hospital Based or Nursing Home Based or 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? **No**

Provide a Yes or No, if your facility has a parent company: **No**

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 monetary 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 1**

The name of the individual owner, partner, director of the corporation or head of the government: **Justin Ferreira - Managing Member**

Street: **148 Market Place Blvd**

City: **Knoxville**

State: **Tennessee**

Zip: **37922**

**Individual Owners, Partners, Director or Head of Government Entity 2**

The name of the individual owner, partner, director of the corporation or head of the government: **Chris Henry - Managing Member**

Street: **148 Market Place Blvd**

City: **Knoxville**

State: **Tennessee**

Zip: **37922**

**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**

Bank Statement with logo.pdf

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**Fees**

Initial License Fee **\$1404.00**

Total Amount Due: **\$1404.00**

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**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, 9<sup>th</sup> Floor, Nashville, TN 37243  
[www.tn.gov/hfc](http://www.tn.gov/hfc) Phone: 615-741-7221

March 31, 2026

Sent Via Email

Martha Glasscock  
Smart Choice Medical, LLC dba A1 Med  
148 Market Place Blvd  
Knoxville, Tennessee 37922

Facility Type: Home Medical Equipment

Dear Martha Glasscock:

It is my pleasure to inform you that your application for licensure of Smart Choice Medical, LLC dba A1 Med located at 148 Market Place Blvd, Knoxville, Tennessee 37922 has been initially approved for providing DME/HME services in all counties in Tennessee effective March 31, 2026 . The license number shall be 1558 . 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 April 22, 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 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'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): 1558 County: Knox

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

Facility Name: Smart Choice Medical, LLC dba A1 Med

Application and fee on file in Central Office (CO)? Yes X No \_\_\_ CON #: \_\_\_ Project #: \_\_\_ Phase: \_\_\_ of \_\_\_  
148 Market Place Blvd. Knoxville, TN 37922

Facility approved for Home Medical Equipment (HME): Providing DME/HME services in all counties in Tennessee.

Sprinklered: \_\_\_\_\_ (Full 100%) Partial: \_\_\_\_\_ (%)

Licensed bed count from: 0 to 0 Number of beds increased/decreased: 0

If secured unit, number of beds in unit: N/A 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: Nancy Mullins RN Date: 03/27/26

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

CD Approved: Yes \_\_\_ No \_\_\_ N/A x Health Survey Required: Yes X No \_\_\_; if Yes, please indicate which region: EAST

Facility's Letter of Notification received in Licensure: Yes \_\_\_ No X  
(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: March 31, 2026 Licensure is recommended: Yes X No \_\_\_  
(Completed by Central Office Licensure Staff)

Mr. Tom Fanel JB 3/31/2026  
Regional Administrator/Facilities Construction Director or Designee Date

Niraj Soni 03/31/2026  
Licensure Program Unit Staff Date

# CERTIFICATE of ACCREDITATION

ACCREDITATION COMMISSION FOR HEALTH CARE CERTIFIES THAT

## *Smart Choice Medical LLC* *d/b/a AI Med* KNOXVILLE, TENNESSEE

HAS DEMONSTRATED A COMMITMENT TO PROVIDING QUALITY CARE AND SERVICES TO CONSUMERS THROUGH COMPLIANCE WITH ACHC'S NATIONALLY RECOGNIZED STANDARDS FOR ACCREDITATION AND IS THEREFORE GRANTED ACCREDITATION FOR THE FOLLOWING:

**DMEPOS**

*Medical Supply Provider Services*  
*Accreditation #76994*

FROM *April 5, 2025*, THROUGH *April 4, 2028*



A handwritten signature in black ink, appearing to read 'John G. ...', written over a horizontal line.

PRESIDENT & CHIEF EXECUTIVE OFFICER

A handwritten signature in black ink, appearing to read 'Roy J. Chew', written over a horizontal line.

CHAIR OF THE BOARD OF COMMISSIONERS