



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

December 28, 2025

REVISED

Sent Via Email

April Hamilton (ahamilton1437@outlook.com)
Your Choice Home Care
205 E. Race St Suite 4
Kingston, TN 37763

Facility Type: Home Health Agencies

Dear April Hamilton:

It is my pleasure to inform you that your application for licensure of HS Holdings LLC doing business as (d/b/a) Your Choice Home Care located at 205 E. Race St Suite 4, Kingston, Tennessee 37763 has been initially approved effective December 28, 2025. The license number shall be 707. 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 January 28, 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 Regional Office phone number is 865-594-0730.

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,
Eddie J. Stewart
Eddie J. Stewart
Health Facilities Program Manager
Health Facilities Commission
Licensure and Regulation

cc: East Tennessee Regional Office

Application Summary

6/15/25 2:09 PM

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Application Detail

License Type: **Home Health Services: Licensed**

Application: **Home Health Services: Initial Application**

Application Date: **06/15/2025 (mm/dd/yyyy)**

Organization Detail

Organization Name: **HS Holdings LLC Your Choice Home Care (ejs)**

Organization Type: **Limited Liability Company**

Addresses**Mailing Address**

Address: **205 205 E. Race St Suite 4**

ROANE**Kingston, TN****37763****US**

Phone Number: **865-771-1066**

Extension:

E-mail Address: **Ahamilton1437@outlook.com**

Administrative

Name: **HS Holdings, LLC Your Choice Home Care (ejs)**

Address: **205 205 E. Race St Suite 4**

ROANE**Kingston, TN****37763****US**

Phone Number: **865-771-1066**

Extension:

E-mail Address: **Ahamilton1437@outlook.com**

Emergency Contact

Name: **HS Holdings, LLC (ejs)**
Your Choice Home Care

Address: **205 205 E. Race St Suite 4**

ROANE

Kingston, TN

37763

US

Phone Number: **865-771-1066**

Extension:

E-mail Address: **Ahamilton1437@outlook.com**

Ownership of Building

Name: **Kevin and April Hamilton**

Address: **205 205 E. Race St Suite 4**

ROANE

Kingston, TN

37763

US

Phone Number: **865-771-1066**

Extension:

E-mail Address: **Ahamilton1437@outlook.com**

Legal Entity

Name: **HS Holdings, LLC**

Address: **205 205 E. Race St Suite 4**

ROANE

Kingston, TN

37763

US

Phone Number: **865-771-1066**

Extension:

E-mail Address:

Ahamilton1437@outlook.com**License Attributes Selected**

Specialty	Home Health Agency
	Home Health Aid Services
	Homemakers Services
	Limited to EEOICPA
	Other Specialty
	Skilled Nursing
Qualification/Certification	EEOICPA -All Counties

Basic License Data

Do you have Branch Offices? If yes, enter number(s) of branch(es).	No
Provide Administrator's Name:	April Hamilton
Provide the Ownership's Name:	April Hamilton HS HOLDINGS, LLC
Ownership Name Continued:	Jamey Stephens (ejs)
Is your facility accredited by a federally approved accrediting body?	No
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
Provide a Yes or No, if your facility has a Parent Company	No
Do you have Other Licensed Facilities in the state of Tennessee and/or other states?	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 monitory penalties for a health care facility in Tennessee or in any other state? **No**

Provide a Yes or No, Do you provide services to a pediatric population? **No**

Provide a Yes or No, Is your agency a provider in the EEOICPA federal program? **Yes**

Administrator's 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: **April Hamilton**

Street: **345 Clear Springs Rd**

City: **Harriman**

State: **Tennessee**

Zip: **37748**

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: **Jamey Stephens**

Street: **318 Clear Springs Rd**

City: **Harriman**

State: **Tennessee**

Zip: **37748**

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

LLC Proof.pdf

Independent Savings Statement.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 Health Services 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 Health Services 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.



APPROVAL FOR FACILITY LICENSURE OR OCCUPANCY

Facility Type: HHA License # (if applicable): 219 County: Roane

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

Facility Name: Your Choice Home Care
Address: 205 E Race Street Suite 4 City: Kingston Zip Code: 37763

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): Providing Home Health services in all counties.

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

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

Total Licensed bed count:

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: Connie Baker Date: 12/22/2025

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 **N/A**
(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: 12/28/2025 Licensure is recommended: Yes X No
(Completed by Central Office Licensure Staff)

 Tom Lane/Patricia Ketterman 12/26/25
Regional Administrator/Facilities Construction Director or Designee Date
 Eddie Stewart 12/28/2025

Licensure Program Unit Staff Date



**State of Tennessee
Health Facilities Commission**

502 Deaderick Street, Andrew Jackson Building, 9th Floor, Nashville, TN 37243
www.tn.gov/hfc Phone: 615-741-2364 hsda.staff@tn.gov

**INITIAL NOTIFICATION OF HOME HEALTH ACCREDITATION FOR
CON EXEMPTION**

Instructions: This form must be filed with the Health Facilities Commission by any person who intends to establish a health care institution or initiates any service specified in T.C.A. 68-11-1607 (a) (3) pursuant to the exemption provided in T.C.A. 68-11-1607 (r) or T.C.A. 68-11-1607 (r). This form must be emailed to hsda.staff@tn.gov.

1. **REPORTING DATE:** 7-14-2025

2. **CONTACT PERSON OR AUTHORIZED AGENT REPORTING EXEMPTION**

April Hamilton
(Name)

BSN, RN Administrator
(Title)

Your Choice Home Care
(Company)

ahamilton1437@outlook.com
(Email Address)

345 Clear Springs Road
(Mailing Address)

865-771-1066
(Telephone Number)

Harriman TN 37748
(City) (State) (Zip)

(Fax Number)

3. **IF SEEKING THE ESTABLISHMENT OF A HOME HEALTH AGENCY UNDER EXEMPTION,
DATE OF LICENSE SUBMISSION:** 6-15-2025

4. **IF CURRENTLY LICENSED, PROVIDE LICENSE #:**

LIST CURRENT LICENSED COUNTIES:

COUNTIES LICENSED UNDER EEOICPA:

COUNTIES LICENSED UNDER PEDIATRIC

COUNTIES LICENSED AS HOME INFUSION ONLY:

LIST ANY EXISTING CERTIFICATE OF NEED LIMITATIONS/CONDITIONS:

5. DESCRIPTION OF EXEMPTED ACTIVITY:

Limited to EEOICPA

LIST OF EXEMPTED COUNTIES TO BE ADDED UNDER THE FOLLOWING TYPES:

PEDIATRIC:

EEOICPA:

All Counties

6. NAME AND ADDRESS OF PROVIDER

Your Choice Home Care

(Name)

205 E. Race Street Suite 4

(Street Address)

Kingston

(City)

TN

(State)

37763

(Zip)

7. ACCREDITATION (must be completed within 2 years of initial licensure)

Please Check



Community Health Accreditation Program, Inc.



Accreditation Commission for Health Care and/or other accrediting body with deeming authority for home health services from CMS and participation in the Medicare Quality Initiatives



Outcome and Assessment Information Set, and Home Health Compare, or other nationally recognized accrediting organization, for Home Health projects;

I UNDERSTAND THAT A HOME HEALTH AGENCY THAT PROVIDES HOME HEALTH SERVICES WITHOUT A CERTIFICATE OF NEED TO PEDIATRIC AND/OR EEOICPA PATIENTS THAT FAILS TO COMPLY WITH THE ACCREDITATION REQUIREMENTS IS SUBJECT TO LICENSURE SANCTIONS.

April Hamilton

Signature of authorized agent

7-14-2025

Date

April Hamilton

Printed Name