



HOME MEDICAL EQUIPMENT  
APPLICATION FOR INITIAL LICENSURE

RECEIVED  
AUG 19 2025  
BY: .....

F-1533  
App# 23655  
ETRO/ETSC

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 Cala Health, Inc.

**Location of the Facility:**

Street 1800 Gateway Drive, Suite 120 City San Mateo

County San Mateo State CA Zip 94404

Phone Number ( 408-393-3483 CNS ) Fax Number ( 833 ) 615-9344

Twenty-four (24) Hour Emergency Phone Number ( 408-393-3483 CNS )

Business Customer Service Phone Number with twenty-four (24) hour access/seven (7) days a week ( 888 ) 699-1009

E-Mail Address CustomerCare@CalaHealth.com

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

**Administrator Information:**

Administrator Steve Higa

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

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Ownership of Building:**

Name SC Properties / Jasmine Barajas Phone Number ( 650 ) 434-8805

Street 1810 Gateway Drive Suite 120

City San Mateo State CA Zip 94404

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

2. Number of branch offices: 0

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.**

\* SEE ATTACHMENT 1 FOR CALA BANK ACCOUNT STATEMENT

**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 Cala Health, Inc. Phone Number ( 415 ) 890-3961

Street 1800 Gateway Drive, Suite 120

City San Mateo State CA Zip 94404

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

Name	Street	City, State, Zip
<u>CSJ Deanna Harshbarger.</u>	<u>1800 Gateway Dr, Ste 120</u>	<u>San Mateo, CA 94404</u>
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          N/A

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.** 10/24/2028 iT

Yes  No          Expiration Date         

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

Name N/A Phone Number (      )  
Address \_\_\_\_\_

4. a. If a corporation, is there a holding company? Yes \_\_\_\_\_ No X

b. If yes, list the name, address and phone number of the holding company:

Name \_\_\_\_\_ Phone Number (      ) \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

5. a. Are any owners of the disclosing entity or also owners of other health care facilities in Tennessee and/or other states? Yes \_\_\_\_\_ No X

b. If yes, list names and addresses of all such facilities:

\_\_\_\_\_  
\_\_\_\_\_

6. a. Do you have a contract with a management firm to operate this facility? Yes \_\_\_\_\_ No X

If yes, specify dates: From \_\_\_\_\_ To \_\_\_\_\_

b. If yes, please specify name of firm: \_\_\_\_\_

Phone Number (      ) \_\_\_\_\_

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

7. For any item in (7) a-h below, please identify, explain and provide documentation of the item(s) noted if response is "Yes". Have either the licensed entity for any of the other health care facilities in Tennessee and/or other states on the list in question (5.b.) above, OR the management firm listed in question (6.) above; been subjected to any of the following within the last (5) years:

**a. Licensure**

i) denied a license ? Yes \_\_\_\_\_ No X

ii) had a license suspended or revoked by any state licensure agency? Yes \_\_\_\_\_ No X

iii) been subject to a final order or judgment in a state licensure action? Yes \_\_\_\_\_ No X

**b. Convictions**

i) convicted of a criminal offense related to that person's involvement in any program under any state or Federal health care program (including Medicare, Medicaid, and Tricare)? Yes \_\_\_\_\_ No X

**c. Exclusion**

i) excluded from participation in Federal health care programs (Medicare, Medicaid, CHIP, or Tricare) in the past? Yes \_\_\_\_\_ No X

*(Note: "Excluded" is defined as a provider or entity has been told by the Department of Health and Human Services, Office of the Inspector General (HHS-OIG) that they may no longer be a provider for any federally funded healthcare program).*



**STATE OF TENNESSEE**

County of \_\_\_\_\_

The above named applicant (print name) \_\_\_\_\_, 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.

*AG please see attached*

Subscribed to and sworn to on this \_\_\_\_\_ day of \_\_\_\_\_ (Month) (Year)

Notary Public: \_\_\_\_\_

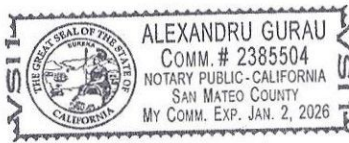
My commission expires: \_\_\_\_\_

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


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 San Mateo

Subscribed and sworn to (or affirmed) before me on this 14  
day of August, 2025, by Stephen Masami Higa,  
proved to me on the basis of satisfactory evidence to be the  
person(s) who appeared before me.



(Seal)

Signature 



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

December 22, 2025

Sent Via Email

Steve Higa  
Cala Health, Inc  
1800 Gateway Drive Suite 120  
San Mateo, California 94404

Facility Type: Home Medical Equipment

Dear Steve Higa:

It is my pleasure to inform you that your application for licensure of Cala Health Inc located at 1800 Gateway Drive Suite 120, San Mateo, California 94404 has been initially approved for providing DME/HME services to all counties in Tennessee effective December 22, 2025 . The license number shall be 1533. 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 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)

cc: East Tennessee Regional Office



**APPROVAL FOR FACILITY LICENSURE OR OCCUPANCY**

Facility Type: HME License # (if applicable): 1533 County: San Mateo

Initial  Renovation \_\_\_\_\_ Satellite/Off Campus Location \_\_\_\_\_

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

Facility Name: Cala Health

Address: 1800 Gateway Drive Suite 120 City: San Mateo, California Zip Code: 94404

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): Providing DME/HME services to 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: 12/12/25

Fire Safety: See attached application Date: \_\_\_\_\_

CD Approved: Yes  No \_\_\_\_\_ Health Survey Required: Yes  No \_\_\_\_\_; if Yes, please indicate which region: EAST

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 N/A  
(NOTE: With exception of Initial Licensure Approvals)

Effective date: December 22 2025 Licensure is recommended: Yes  No \_\_\_\_\_  
(Completed by Central Office Licensure Staff)

Tom Lane/Lb \_\_\_\_\_ 12/16/2025

Regional Administrator/Facilities Construction Director or Designee \_\_\_\_\_ Date \_\_\_\_\_  
Niraj \_\_\_\_\_ 12/22/25  
Licensure Program Unit Staff \_\_\_\_\_ Date \_\_\_\_\_

# CERTIFICATE *of* ACCREDITATION

ACCREDITATION COMMISSION FOR HEALTH CARE CERTIFIES THAT

## *Cala Health* SAN MATEO, CALIFORNIA

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

*Home/Durable Medical Equipment Services*

*Accreditation #76950*

FROM *October 25, 2025*, THROUGH *October 24, 2028*



PRESIDENT & CHIEF EXECUTIVE OFFICER



CHAIR OF THE BOARD OF COMMISSIONERS

