

Application Summary

8/18/25 2:36 PM

App # 23653
ETRO/ITSD
F-1531

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Application Detail

License Type: **Home Medical Equipment: Licensed**
Application: **Home Medical Equipment: Initial Application**
Application Date: **08/18/2025 (mm/dd/yyyy)**

Organization Detail

Organization Name: **Total Medical Supply, Inc**
Organization type: **Corporation**

Addresses

Main Address

Address: **5610 Richmond Road**
BOWIE
Texarkana, TX
75503-0500
US
Phone Number: **877-670-1120 ext1005**
Extension:
E-mail Address: **compliance@tmscares.com**

Administrative

Name: **Total Medical Supply, Inc**
Address: **PO Box 5427**
BOWIE
Texarkana, TX
75505
US
Phone Number: **877-670-1120 ext1005**
Extension:
E-mail Address: **compliance@tmscares.com**

Emergency Contact

Name: **Total Medical Supply, Inc**

Address: **PO Box 5427**

BOWIE

Texarkana, TX

75505

US

Phone Number: **877-670-1120 ext 1005**

Extension:

E-mail Address: **compliance@tmscares.com**

Ownership of Building

Name: **DonCapital, LLC**

Address: **5610 Richmond Road**

BOWIE

Texarkana, TX

75503-0500

US

Phone Number: **877-670-1120 ext # 1005**

Extension:

E-mail Address: **compliance@tmscares.com**

Legal Entity

Name: **Total Medical Supply, Inc**

Address: **PO Box 5427**

BOWIE

Texarkana, TX

75505

US

Phone Number: **877-670-1120**

Extension:

E-mail Address:

compliance@tmscares.com

License Attributes Selected

Qualification/Certification

All Counties

~~Out of State Alabama~~

~~Out of State Alaska~~

~~Out of State Arizona~~

~~Out of State Arkansas~~

~~Out of State California~~

~~Out of State Colorado~~

~~Out of State Connecticut~~

~~Out of State Delaware~~

~~Out of State District of Columbia~~

~~Out of State Florida~~

~~Out of State Georgia~~

~~Out of State Hawaii~~

~~Out of State Idaho~~

~~Out of State Illinois~~

~~Out of State Indiana~~

~~Out of State Iowa~~

~~Out of State Kansas~~

~~Out of State Kentucky~~

~~Out of State Louisiana~~

~~Out of State Maine~~

~~Out of State Maryland~~

~~Out of State Massachusetts~~

~~Out of State Michigan~~

~~Out of State Minnesota~~

Out of State Texas

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: **Julie Franklin**

Provide the Ownership's Name:

Total Medical Supply, Inc (NS)

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

If answered yes accredited, must provide expiration date of accreditation.

09/25/2028 (mm/dd/yyyy) (NS)

What type of Home Care Organization: Hospital Based or Nursing Home Based or Free Standing?

Free Standing HME (NS)

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 monitory penalties for a health care facility in Tennessee or in any other state? **No**

Does your facility have a physical location in Tennessee?: **No**

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: **Donald Reid**

Street: **6624 Lakeridge Drive**

City: **Texarkana**

State: **Texas**

Zip: **75503**

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

BS 07.2025.CSV.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
502 Deaderick Street, 9th Floor, Nashville, TN 37243
www.tn.gov/hfc Phone: 615-741-7221

December 22, 2025

Sent Via Email

Julie Franklin
Total Medical Supply, Inc
PO Box 5427
Texarkana, Texas 75505

Facility Type: Home Medical Equipment

Dear Julie Franklin:

It is my pleasure to inform you that your application for licensure of Total Medical Supply, Inc located at 5610 Richmond Road, Texarkana, Texas 75503-0500 has been initially approved for providing DME/HME services in all Tennessee counties effective December 22, 2025 . The license number shall be 1531. 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

cc: East Tennessee Regional Office



APPROVAL FOR FACILITY LICENSURE OR OCCUPANCY

Facility Type: HME License # (if applicable): 1531 County: Bowie

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

Facility Name: Total Medical Supply

Address: 5610 Richmond Rd City: Texarkana Texas Zip Code: 75503

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 in all Tennessee counties.

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
Miej Date 12/22/25
Licensure Program Unit Staff Date

CERTIFICATE *of* ACCREDITATION

ACCREDITATION COMMISSION FOR HEALTH CARE CERTIFIES THAT

Total Medical Supply, Inc.
TEXARKANA, TEXAS

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 #97986

FROM *September 26, 2025*, THROUGH *September 25, 2028*



PRESIDENT & CHIEF EXECUTIVE OFFICER



CHAIR OF THE BOARD OF COMMISSIONERS

