Application Summary

Application Detail

License Type:	**Home Health Services: Licensed**
Application:	**Home Health Services: Initial Application**
Application Date:	**06/04/2025 (mm/dd/yyyy)**

Organization Detail

Organization Name:	**RAMONA GALLAHER**
Organization Type:	**Single Proprietor**

Addresses

Mailing Address

Address:	**4324 LONAS DRIVE**
	KNOX
	KNOXVILLE, TN
	37909
	US
Phone Number:	**865-306-4044**
Extension:	
E-mail Address:	**RRGALLAHER@ICLOUD.COM**

Administrative

Name:	**RAMONA GALLAHER**
Address:	**4324 LONAS DRIVE**
	KNOX
	KNOXVILLE, TN
	37909
	US
Phone Number:	**865-306-4044**
Extension:	
E-mail Address:	**RRGALLAHER@ICLOUD.COM**

Emergency Contact

Name:	**RAMONA GALLAHER**
Address:	**4324 LONAS DRIVE** **KNOX** **KNOXVILLE, TN** **37909** **US**
Phone Number:	**865-306-4044**
Extension:	
E-mail Address:	**RRGALLAHER@ICLOUD.COM**

Ownership of Building

Name:	**RAMONA GALLAHER**
Address:	**4324 LONAS DRIVE** **KNOX** **KNOXVILLE, TN** **37909** **US**
Phone Number:	**865-306-4044**
Extension:	
E-mail Address:	**RRGALLAHER@ICLOUD.COM**

Legal Entity

Name:	**RAMONA GALLAHER**
Address:	**4324 LONAS DRIVE** **KNOX** **KNOXVILLE, TN** **37909** **US**
Phone Number:	**865-306-4044**

Extension:	
E-mail Address:	**RRGALLAHER@ICLOUD.COM**

License Attributes Selected

Specialty	**Home Health Agency**
	Home Health Aid Services
	Home Medical Equipment
	Medical Supplies & Appliances
	Skilled Nursing
Qualification/Certification	**EEOICPA-Anderson**
	EEOICPA-Knox
	EEOICPA-Roane

Basic License Data

Do you have Branch Offices? If yes, enter number(s) of branch(es).	**0**
Provide Administrator's Name:	**RAMONA GALLAHER**
Provide the Ownership's Name:	**RAMONA GALLAHER**
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?:	**Yes**
Administrator's Name::	**RAMONA GALLAHER**
Administrator's License Number::	**N/A**
Date of Conviction:	**11/01/1997 (mm/dd/yyyy)**
What charges?:	**DRUG CHARGE**
City conviction was in:	**KINGSTON**
County conviction was in:	**ROANE**
State conviction was in:	**TENNESSEE**

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:	**RAMONA GALLAHER**
Street:	**4324 LONAS DR**
City:	**KNOXVILLE**
State:	**Tennessee**
Zip:	**37909**

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**

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?:

File Attachments

2025-05-31 Account Statement.pdf

STATE INT APP-1.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.

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

HFC

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:**

06/04/2025

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

RAMONA R GALLAHER
(Name)
INDEPENDENT
(Company)
4324 LONAS DRIVE
(Mailing Address)
KNOXVILLE, TENNESSEE 37909
(City) (State) (Zip)

LPN
(Title)
RRGALLAHER@ICLOUD.COM
(Email Address)
865-306-4044
(Telephone Number)
865-637-6444
(Fax Number)

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

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

N/A

LIST CURRENT LICENSED COUNTIES:

ROANE, ANDERSON, KNOX

COUNTIES LICENSED UNDER EEOICPA:

ROANE, ANDERSON, KNOX

COUNTIES LICENSED UNDER PEDIATRIC

N/A

COUNTIES LICENSED AS HOME INFUSION ONLY:

N/A

LIST ANY EXISTING CERTIFICATE OF NEED LIMITATIONS/CONDITIONS:

N/A

5. DESCRIPTION OF EXEMPTED ACTIVITY:

CURRENTLY A PROVIDER FOR EEOICPA

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

PEDIATRIC:

EEOICPA:

ROANE, ANDERSON, KNOX

6. NAME AND ADDRESS OF PROVIDER

RAMONA GALLAHER
(Name)

4324 LONAS DRIVE
(Street Address)

KNOXVILLE	TN	37909
(City)	(State)	(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.

Ramona Gallaher

Signature of authorized agent

06/04/2025

Date

Ramona Gallaher

Printed Name

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

August 5, 2026 Sent Via Email

RAMONA GALLAHER (rrgallaher@icloud.com)
4324 LONAS DRIVE
Knoxville, TN 37909

Facility Type: Home Health Agencies

Dear Ramona Gallaher:

It is my pleasure to inform you that your application for licensure of RAMONA GALLAHER located at 4324 LONAS DRIVE, Knoxville, TN 37909 has been initially approved August 5, 2026. The license number shall be 705. 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 August 26, 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 865-594-0730.

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 Unit

cc: East Tennessee Regional Office

State of Tennessee
Health Facilities Commission
665 Mainstream Drive, 2nd Floor, Nashville, TN 37243
www.tn.gov/hfc Phone: 615-741-7221

HFC

June 12, 2025 Sent Via Email

RAMONA GALLAHER
4324 LONAS DRIVE
Knoxville, TN 37909

Dear RAMONA GALLAHER:

This is to acknowledge receipt of your application and fee to apply for licensure of RAMONA GALLAHER. Please review the instruction sheet that you received with the application to apply for licensure so that you are aware of the process for obtaining licensure of your facility. If a certificate of need is required to provide services, you will need to contact Health Facilities Commission at (615) 741-2364.

Please remember that if you are applying for licensure of a facility that requires architectural plan review contact Plans Review for complete and details and procedures at (615) 741-6998. You must submit those plans along with the plans review fee prior to scheduling a survey. **For Homes for the Aged facilities specifically; TCA-368-11-202 allows "schematics shall be submitted to the department for approval of plans and specifications, converting and existing single-family dwelling" with six (6) or less beds.**

It is your responsibility to contact the East Tennessee Regional Office to request a survey of your facility. Please submit the request in writing to East Tennessee Regional Administrator, 7175 Strawberry Plans Pike, Suite 103, Knoxville, Tennessee 37914. If you would like to fax the request to Debra Verna the fax number is 865-594-5298.

Your application and fee will be held in a pending status until you are recommended by the Regional Office for licensure. Once the recommendation for licensure is received from the regional office, your facility will receive a letter for "Initial Approval." Admission of patients MAY NOT occur until the facility's receipt of the "Initial Approval" letter. Your application will be presented before the Board for Licensing Health Facilities Commission for ratification and final approval at the next regularly scheduled commission meeting. Your facility CAN operate once you receive the "Initial Approval."

This application will only be good for one (1) year from the date of receipt. If the initial licensure has not occurred within that one (1) year period, you will be required to submit a new application and fee unless you have contacted our office in writing extending your application.

In the event that a certificate of need is required prior to obtaining a license for this facility the application file will be closed the day following the expiration date of the certificate of need.

Should you have any questions or if I can be of assistance to you please call me at (615) 741-7221 or you may email me at Angela.A.tyler@tn.gov.

Sincerely,

Angela Tyler

Angela Tyler

HFC

APPROVAL FOR FACILITY LICENSURE OR OCCUPANCY

Facility Type: HHA License # (if applicable): 705 County: Knox

Add Counties _____ Initial X Renovation _____ Satellite/Off Campus Location_____

Physical Plant/Services/New Addition _____ (Circle One) Relocation/Replacement Facility_____ (Circle One)

Facility Name: Ramona Gallaher

Address: 4324 Lonas Drive City: Knoxville Zip Code: 37909

Application and fee on file in Central Office (CO)?: Yes X No ____ CON #: DOL

Project #: _____ Phase: _____ of _____

Facility approved for (if satellite/off campus site include address): Approved for Knox, Roane and Anderson 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: 12/03/25

Fire Safety: _____ Date: _____

CD Approved: Yes____ No____ N/A____ Health Survey Required: Yes X No____; if Yes, please indicate which region:_____

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 ✓
(NOTE: With exception of Initial Licensure Approvals)

Effective date: 8/5/2026 Licensure is recommended: Yes ✓ No ____
(Completed by Central Office Licensure Staff)

Tom Lane/Lb 12/05/2025
Regional Administrator/Facilities Construction Director or Designee Date

Eddie Stewart 8/5/2026
Licensure Program Unit Staff Date