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## HEALTHCARE FACILITY REGULATION DIVISION

**RE: Change of Ownership (CHOW) for Ambulatory Surgical Centers (State Licensure)**

This letter will provide information regarding the CHOW of your Ambulatory Surgical Center (ASC). This Section is responsible for licensing ASCs under State Law and assisting the Centers for Medicare and Medicaid Services in performing the certification function for those providers wishing to participate in the Medicare program.

### **CHOW APPLICATION REQUIREMENTS:**

Before this Section can provide your facility with a license to operate an ASC, you must submit the following documents:

- 1 A completed Application and Initial License Fee Coupon with payment as directed on the coupon. The coupon may be found at:  
[http://dch.georgia.gov/vgn/images/portal/cit\\_1210/32/27/163015381Licensing\\_Initial\\_16\\_S\\_ave.pdf](http://dch.georgia.gov/vgn/images/portal/cit_1210/32/27/163015381Licensing_Initial_16_S_ave.pdf) (blanks are underscores)
- 2 A completed application to operate an ASC.
- 3 A copy of the CON (Certificate of Need) or LNR (Letter of Non-Reviewability, if applicable, for the new owner.
- 4 Notarized Identity Affidavits for ALL owners
- 5 Copy of the signed and dated Bill of Sale for the ASC.

### **ISSUANCE OF A PERMIT NUMBER:**

Please mail the completed application, the CON or LNR, and the notarized affidavits to the attention of the Director of the Acute Care Section at 2 Peachtree St., NW, Suite 31-447, Atlanta, Georgia 30303-3142 as soon as possible. The signed and dated Bill of Sale may be faxed to 404-657-8934. A new permit number and permit will be issued with the effective date of the CHOW.

Under State law and regulations, you must notify this Section at least 30 days in advance of any change in ownership. The State Permit is not transferable.

### **MEDICARE APPLICATION REQUIREMENTS:**

A supplier enrollment application, Form CMS-855B must be completed and submitted to Cahaba Government Benefits Administrators for processing. The form may found and downloaded from: <http://www.cms.hhs.gov/CMSforms/downloads/cms855b.pdf> along with a user's guide providing instructions for completing the forms.

The completed form must be submitted directly to Cahaba GBA, Attn: Georgia Provider Enrollment, P.O. Box 12967, Birmingham, AL 35202. Cahaba may be reached by calling Provider Enrollment at 1-866-582- 3246. If you require help or assistance in completing the Form CMS 855B, contact Cahaba, not the Healthcare Facility Regulation Division (HFRD). Cahaba will notify HFRD of its recommendation for approval or denial of enrollment for your ASC. HFRD cannot complete the CHOW and issue a permit until Cahaba approves your enrollment application (Form CMS-855B) and HFRD is notified.

The new owner may refuse to accept assignment of the previous owner's Medicare provider agreement, which means that the effective date of termination of the existing provider agreement is the CHOW date. The refusal to accept assignment must be put in writing by the new owner and forwarded to HFRD 45 calendar days prior to the CHOW date. The refusal must be a letter that documents the new owner's desire not to accept the current provider agreement. If the CHOW goes into effect without a refusal on record, HFRD concludes that the agreement has been automatically assigned to the new owner and completes processing of the CHOW.

If a new owner refuses to accept assignment and also wishes to participate in the Medicare program, the new owner must complete and submit Form CMS-377, Ambulatory Surgical Center Request for Certification in the Medicare Program, and Form CMS-370, Health Insurance Benefits Agreement, to HFRD; complete and submit Form CMS 855B to Cahaba; obtain approval of Form CMS 855B from Cahaba; and have an initial survey performed by an approved Accrediting Organization (AO) using criteria for the Medicare deemed status program. The earliest possible Medicare effective date is the date that all of these requirements are met. The Form CMS-855B must be submitted prior to the CHOW date. Survey by the AO may not be performed until (1) after the CHOW and (2) after Cahaba makes a recommendation to HFRD for approval. The new owner will not be enrolled in the Medicare program until a survey is conducted by the AO and HFRD is provided with a copy of the full report of the AO's survey findings and accreditation letter.

If we can be of further assistance to you, please contact the Acute Care Section Director at (404) 657-5440.

**ENCLOSURES:**  
License Application  
Form CMS-377  
Form CMS-370

**DEPARTMENT OF COMMUNITY HEALTH  
HEALTHCARE FACILITY REGULATION DIVISION  
ACUTE CARE SECTION  
2 PEACHTREE STREET NW  
SUITE 31-447  
ATLANTA, GEORGIA 30303-3142**

**APPLICATION FOR A PERMIT TO OPERATE AN AMBULATORY SURGICAL TREATMENT CENTER**

Pursuant to O.C.G.A. 31-7-1 et seq. Application is hereby made to operate the Ambulatory Surgical Center which is identified as follows:

**SECTION A - IDENTIFICATION**

Date of application: \_\_\_\_\_ Type of application:  Initial  Change of Ownership  Address  Name  
 Scope of Services  Other \_\_\_\_\_

Name of Ambulatory Surgical Center (This name will appear on Permit)			
_____			
Address _____	City _____	County _____	Zip+4 _____
Phone: (____) _____ - _____ FAX: (____) _____ - _____ E-Mail Address: _____			
_____			
Official Name and Address of ASTC Governing Body			
_____			
Name of Person Delegated Responsibility for Day-to-Day Management/Administration of ASTC (regulation 290-5-35-.03 (5))			
_____			Title: _____
_____			
Agent for Service/Legal Representative name: _____			
_____			
Complete Address of Agent for Service/Legal Representative			
_____			

Classification (check one)

- Single or Multi-Specialty (Certificate of Need required)  
 Physician Owned Single Specialty (Letter of Nonreviewability required)

List Type and Scope of Surgical Services (refer to regulation 290-5-33-. 04)

_____		
Number of Operating Rooms	Number of Minor Procedure Rooms	Patient Capacity of Recovery Rooms
_____	_____	_____

Days and Hours of Operation (for the ASTC only)

**SECTION B – STAFF**

List Names, Addresses, and Specialty of Professional Director and Other Physicians on the Medical Staff

Professional Director: \_\_\_\_\_

Other Physicians on the Medical Staff: \_\_\_\_\_

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

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**SECTION C – PROVISIONS FOR CARE**

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List All Health Care Providers with whom the Center has Arrangements/Contracts (specify services)

Name

Service


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**SECTION D – OWNERSHIP INFORMATION**

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Type of Ownership

Individual     Partnership     Corporation     Other (specify) \_\_\_\_\_

1. List Names and Addresses of All Owners with 5% or More Interest (refer to regulation 290-5-33-.03 (2))

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2. Centers Organized as a Corporation or Partnership – List Names and Addresses of Officers of the Corporation or Principle Partners

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**SECTION E– Attach Affidavit of Lawful Presence****SECTION F- CERTIFICATION**

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I certify that this Facility is devoted primarily to the provision of **SURGICAL** treatment to patients not requiring hospitalization and that this facility will operate in accordance with the rules and regulations governing ambulatory surgical treatment centers. I further certify that the information provided in connection with this application is true to the best of my knowledge and belief. (Refer to regulation 290-5-33-.01 (A))

Signature of Principal Officer of Governing Board

Title

Date

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**(For Department Of Community Health Use Only)**

\_\_\_\_\_

Date Received

\_\_\_\_\_

Center Permit Number

\_\_\_\_\_

Reviewed by

\_\_\_\_\_

Effective Date

Fire Safety Statement Attached:  Yes  No

\_\_\_\_\_

Approved

\_\_\_\_\_

Date

Copy of CON or LNR Attached:  Yes  No



According to the Paperwork Reduction of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0266. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, searching existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimates(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

**HEALTH INSURANCE BENEFITS AGREEMENT**  
*(AGREEMENT WITH AMBULATORY SURGICAL CENTER PURSUANT TO  
SECTION 1832(a)(2)(F) OF THE SOCIAL SECURITY ACT)*

For the purpose of establishing eligibility for payment under title XVIII of the Social Security Act,

*(Insert Name of Facility)*

hereinafter referred to as the Ambulatory Surgical Center, hereby agrees:

- (A) to maintain compliance with the conditions set forth in part 416 of chapter IV, title 42 of the Code of Federal Regulations, and to report promptly to the Centers for Medicare & Medicaid Services (CMS) any failure to do so;
- (B) not to charge a Medicare beneficiary or any other person for items or services for which the beneficiary is entitled to have payment made in accordance with part 416 of chapter IV, title 42 of the Code of Federal Regulations;
- (C) to refund as promptly as possible any money incorrectly collected from beneficiaries or from someone on his or her behalf;
- (D) to furnish to CMS, if requested, information necessary to establish payment rates specified in §416.120 and §416.130 in the form and manner that CMS requires;
- (E) to accept assignment for all facility services furnished in connection with covered surgical procedures as specified in §416.85; and
- (F) to comply with statutory and regulatory requirements regarding revision of the Quality Improvement Organization that contracts with CMS to review ambulatory surgical procedures.

This agreement, upon submission by the Ambulatory Surgical Center and upon acceptance for filing by the Secretary of Health and Human Services, shall be binding on the Ambulatory Surgical Center and the Secretary. The agreement may be terminated by either party in accordance with regulations. In the event of termination, payment will not be available for Ambulatory Surgical Center services furnished on or after the effective date of termination.

This agreement shall become effective on the date specified below by the Secretary or the Secretary's delegate, and shall remain in effect unless terminated. In the event of a transfer of ownership of the Ambulatory Surgical Center, **this Agreement Shall Remain Effective** as between the Secretary of Health and Human Services and the Transferee.

ATTENTION: Read the following provision of Federal law carefully before signing.

Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or make any false, fictitious or fraudulent statement or representation, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement, or entry, shall be fined not more than \$10,000 or imprisoned not more than 5 years or both (18 U.S.C. section 1001).

Accepted for the Ambulatory Surgical Center by:

Accepted for the Secretary of Health and Human Services by:

NAME (SIGNATURE)

NAME (SIGNATURE)

TITLE

TITLE

DATE

DATE

EFFECTIVE DATE OF AGREEMENT

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0266. The time required to complete this information collection is estimated to average 5 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850.

**INSTRUCTIONS FOR COMPLETING AFFIDAVIT  
REQUIRED TO BECOME LICENSED**

In order to obtain a license from the Department of Community Health to operate your business, Georgia law requires every applicant to complete an affidavit (sworn written statement) before a Notary Public that establishes that you are lawfully present in the United States of America. This affidavit is a material part of your application and must be completed truthfully. Your application for licensure may be denied or your license may be revoked by the Department if it determines that you have made a material misstatement of fact in connection with your application to become licensed. If a corporation will be serving as the governing body of the licensed business, the individual who signs the application on behalf of the corporation is required to complete the affidavit. Please follow the instructions listed below.

1. Review the list of Secure and Verifiable Documents under O.C.G.A. §50-36-2 which follows these instructions. This list contains a number of identification sources to choose from that are considered secure and verifiable that you can use to establish your identity, such as a U.S. driver's license or a U.S. passport. Locate one original document on the list to bring to the Notary Public to establish your identity.
2. Print out the affidavit. (If you do not have access to a printer, you can go to your local library or an office supply store to print out the document for a small fee.)
3. Fill in the blanks on the Affidavit above the signature line only—**BUT DO NOT SIGN THE AFFIDAVIT at this time.** (You will sign the affidavit in front of the Notary Public.) Fill in the name of the secure and verifiable document (for example, Georgia driver's license, U.S. passport) that you will be presenting to the Notary Public as proof of your identity. **CAUTION: Put your initials in front of only ONE of the choices listed on the affidavit and described here below:**
  - Option 1) is to be initialed by you if you are a United States citizen; or
  - Option 2) is to be initialed by you if you are a legal permanent resident of the United States. You are not a U.S. citizen but you have a green card; or
  - Option 3) is to be initialed by you if you are a qualified alien or non-immigrant (but not a U.S. citizen or a legal permanent resident) with an alien number issued by the Department of Homeland Security or other federal immigration agency. Fill in the alien number, as well.
4. Find a Notary Public in your area. Check the yellow pages, the internet or with a local business, such as a bank.
5. Bring your affidavit and the identification you selected (from the list of Secure and Verifiable Documents) to appear before the Notary Public.

- 6. Show the Notary Public your secure and verifiable identification (anything on List that follows these instructions) and state under oath in the presence of the Notary Public that you are who you say you are and that you are in the United States lawfully. Then sign your name.**
- 7. Make certain that the Notary Public signs and dates the affidavit and puts when the notary commission expires.**
- 8. Make a copy of the affidavit and the identification that you presented to the Notary Public for your own records.**
- 9. Attach the ORIGINAL SIGNED AFFIDAVIT and a copy of the identification you presented to your application for licensure. DO NOT SEND US YOUR AFFIDAVIT SEPARATELY. IT MUST BE INCLUDED IN THE COMPLETE APPLICATION PACKET WHICH YOU MAIL TO US.**

## **Secure and Verifiable Documents Under O.C.G.A. § 50-36-2**

Issued August 1, 2011 by the Office of the Attorney General, Georgia

The Illegal Immigration Reform and Enforcement Act of 2011 (“IIREA”) provides that “[n]ot later than August 1, 2011, the Attorney General shall provide and make public on the Department of Law’s website a list of acceptable secure and verifiable documents. The list shall be reviewed and updated annually by the Attorney General.” O.C.G.A. § 50-36-2(f). The Attorney General may modify this list on a more frequent basis, if necessary.

The following list of secure and verifiable documents, published under the authority of O.C.G. A. § 50-36-2, contains documents that are verifiable for identification purposes, and documents on this may not necessarily be indicative of residency or immigration status.

- A United States passport or passport card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A United States military identification card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A driver’s license issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- An identification card issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A tribal identification card of a federally recognized Native American tribe, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer. A listing of federally recognized Native American tribes may be found at: <http://www.bia.gov/WhoWeAre/BIA/OIS/TribalGovernmentServices/TribalDirectory/ind/ex.htm> [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A United States Permanent Resident Card or Alien Registration Receipt Card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- An Employment Authorization Document that contains a photograph of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A passport issued by a foreign government [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

- A Merchant Mariner Document or Merchant Mariner Credential issued by the United States Coast Guard [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A Free and Secure Trade (FAST) card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]
- A NEXUS card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]
- A Secure Electronic Network for Travelers Rapid Inspection (SENTRI) card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]
- A driver's license issued by a Canadian government authority [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A Certificate of Citizenship issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-560 or Form N-561) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]
- A Certificate of Naturalization issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-550 or Form N-570) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]
- In addition to the documents listed herein, if, in administering a public benefit or program, an agency is required by federal law to accept a document or other form of identification for proof of or documentation of identity, that document or other form of identification will be deemed a secure and verifiable document solely for that particular program or administration of that particular public benefit. [O.C.G.A. § 50-36-2(c)]

**O.C.G.A. § 50-36-1(e)(2) Affidavit**

By executing this affidavit under oath, as an applicant for a **license, permit or registration**, as referenced in O.C.G.A. § 50-36-1, from the **Department of Community Health, State of Georgia**, the undersigned applicant verifies one of the following with respect to my application for a public benefit:

- 1) \_\_\_\_\_ I am a United States citizen.
- 2) \_\_\_\_\_ I am a legal permanent resident of the United States.
- 3) \_\_\_\_\_ I am a qualified alien or non-immigrant under the Federal Immigration and Nationality Act with an alien number issued by the Department of Homeland Security or other federal immigration agency.

My alien number issued by the Department of Homeland Security or other federal immigration agency is:\_\_\_\_\_.

The undersigned applicant also hereby verifies that he or she is 18 years of age or older and has provided at least one secure and verifiable document, as required by O.C.G.A. § 50-36-1(e)(1), with this affidavit.

The secure and verifiable document provided with this affidavit can best be classified as:  
\_\_\_\_\_.

In making the above representation under oath, I understand that any person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall be guilty of a violation of O.C.G.A. § 16-10-20, and face criminal penalties as allowed by such criminal statute.

Executed in \_\_\_\_\_ (city), \_\_\_\_\_(state).

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Printed Name of Applicant

SUBSCRIBED AND SWORN  
BEFORE ME ON THIS THE  
\_\_ DAY OF \_\_\_\_\_, 20\_\_

\_\_\_\_\_  
NOTARY PUBLIC  
My Commission Expires: