ADULT DAY CENTER/ADULT DAY HEALTH SERVICE APPLICATION CHECKLIST

For your convenience, an application checklist has been created to outline the required documents for each application submission. Please upload all required documents in your Adult Day Center (ADC) or Adult Day Health Services (ADHS) Application Packet. As a reminder, all policies and procedures must be established as part of the requirement for regulations and readily available upon request. To prevent any delays in the review process, please submit all documents at once.

Upon application submission and payment, if required, you will receive an acknowledgement email. Applications are reviewed in the order they are received. The initial review period is 60 days from the date of receipt. Failure to submit documents accurately and timely can result in a longer review period.

The official rules for Adult Day Center and Adult Day Health Services are on record with the Georgia Secretary of State’s Office at http://rules.sos.state.ga.us/. A courtesy copy of the rules for Adult Day Center and Adult Day Health Services can be found on Healthcare Facility Regulation Division website at https://dch.georgia.gov/divisionsoffices/healthcare-facility-regulation/hfr-laws-regulations.

The link to access the online application portal is https://forms.dch.georgia.gov/Forms/HFRD-Applications-and-Waivers-Intake. All written correspondence regarding the status of your application will be sent to the email address provided on your application. If we request additional documentation, please click on the link at the bottom of the email from workflow@dch.ga.gov and upload the requested documents. Please continue to check your email for status updates including junk/spam email.

For application related questions, please contact us at hfrd.applicationswaivers@dch.ga.gov and reference your facility name and/or application number.

Initial/New Permit

1. Application - completed and signed by the Owner
   If a corporation - include Certificate of Incorporation and Articles of Incorporation for ALL corporations having an interest in the adult day center
   If partnership - include Partnership Agreement
   If Limited Liability Company (LLC) - include Certificate of Organization and Articles of Organization for ALL LLCs with an interest in the adult day center
   If a non-profit - include documentation of non-profit status [501(c) 3]
   If Individual - include statement of all owners and percentage of ownership

2. Documentation of County/City Zoning Approval or applicable documents

3. A completed Affidavit of Personal Identification
   NOTE: Only the Affidavit in this licensure package is acceptable.

4. Provide copy of applicant’s ID that was shown to notary

5. A copy of Proof of Ownership for the property or a copy of the Lease Agreement
6. Fire Safety Inspection Report with no violations or hazards identified from the appropriate fire safety authority showing capacity load (must be dated within 6 months of application submission)

7. Floor Sketch (label all rooms, doors, windows and provide measurements for all common areas)

8. Administrator & Owner Survey Form signed and dated by the Owner

9. Completed fingerprinting through Georgia Criminal Background Check System (GCHEXS) for the administrators, managers, and owners (satisfactory determination letter on DCH letterhead must be dated within 12 months of application submission). For fingerprint background check requirements, visit https://dch.georgia.gov/georgia-criminal-background-check-system-gchexs/georgia-criminal-background-check-system-gchexs.

10. Written approval for water source and sewage disposal system (If the facility uses a septic system, complete the Water and Septic Tank Report Form)

11. Food Service Permit (ADHC with 24 or more Participants) from the county Public Health Department

12. A list of any other Adult Day Centers operated by the governing body

13. If transportation services are provided, please provide proof of insurance coverage for property damage, uninsured motorist, bodily injury, and proof of vehicle registration.

14. A list of location mobile Adult Day Centers operated by the governing body (Name and Address)

15. A copy of the Registered Nurse License (*Health Model*)

16. Pictures of accessible Bathroom and Shower

17. Licensure fee is required. For more information, see Schedule of Licensure Activity Fees.

**Change of Ownership (CHOW)**

1. Application – completed and signed by the Owner
   If a corporation – include Certificate of Incorporation and Articles of Incorporation for ALL corporations having an interest in the adult day center
   If partnership – include Partnership Agreement
   If Limited Liability Company (LLC) – include Certificate of Organization and Articles of Organization for ALL LLCs with an interest in the adult day center
   If a non-profit – include documentation of non-profit status [501© 3]
   If Individual – include statement of all owners and percentage of ownership.

2. Provide a Bill of Sale or Transaction Agreement for the business purchase

3. A completed Affidavit of Personal Identification
   NOTE: Only the Affidavit in this licensure package is acceptable.

4. **Provide copy of applicant’s ID that was shown to notary**

5. A copy of Proof of Ownership for the property or a copy of the Lease Agreement
6. Administrator & Owner Survey Form signed and dated by the Owner

7. Completed fingerprinting through Georgia Criminal Background Check System (GCHEXS) for the administrators, managers, and owners (satisfactory determination letter on DCH letterhead must be dated within 12 months of application submission). For fingerprint background check requirements, visit https://dch.georgia.gov/georgia-criminal-background-check-system-gchexs/georgia-criminal-background-check-system-gchexs.

**Facility Name Change**

1. Application - completed and signed by the Owner

2. A completed Affidavit of Personal Identification
   NOTE: Only the Affidavit in this licensure package is acceptable.

3. Provide copy of applicant’s ID that was shown to notary

**Governing Body Name Change**

1. Application - completed and signed by the Owner
   If a corporation - include Certificate of Incorporation and Articles of Incorporation for ALL corporations having an interest in the adult day center
   If partnership - include Partnership Agreement
   If Limited Liability Company (LLC) - include Certificate of Organization and Articles of Organization for ALL LLCs with an interest in the adult day center
   If a non-profit - include documentation of non-profit status [501(c) 3]
   If Individual - include statement of all owners and percentage of ownership.

2. Administrator & Owner Survey Form signed and dated by the Owner

3. A completed Affidavit of Personal Identification
   NOTE: Only the Affidavit in this licensure package is acceptable.

4. Provide copy of applicant’s ID that was shown to notary

**Decrease in Capacity**

1. Application - completed and signed by the Owner

2. A completed Affidavit of Personal Identification
   NOTE: Only the Affidavit in this licensure package is acceptable.

3. Provide copy of applicant’s ID that was shown to notary

**Increase in Capacity**

1. Application - completed and signed by the Owner

2. Fire Safety Inspection Report with no violations or hazards identified from the appropriate fire safety authority showing capacity load

3. Floor Sketch (label all rooms, doors, windows and provide measurements for all common areas)
4. A completed Affidavit of Personal Identification
   NOTE: Only the Affidavit in this licensure package is acceptable.

5. Provide copy of applicant’s ID that was shown to notary

Change of Service Level from ADC to ADHC

1. Application - completed and signed by the Owner

2. A completed Affidavit of Personal Identification
   NOTE: Only the Affidavit in this licensure package is acceptable.

3. Provide copy of applicant’s ID that was shown to notary

4. A copy of the Registered Nurse License

5. Pictures of accessible Bathroom and Shower

Change of Service Level from ADHC to ADC

1. Application - completed and signed by the Owner

2. A completed Affidavit of Personal Identification
   NOTE: Only the Affidavit in this licensure package is acceptable.

3. Provide copy of applicant’s ID that was shown to notary
# ADULT DAY CENTER APPLICATION

## Check All That Apply
- New Permit
- Change of Address (not location)
- Change of Governing Body (ownership)
- Change of Capacity
- Change of Center’s Name
- Adult Day Care
- Adult Day Health

## 1. Name of Center
   (Area Code) Telephone

## 2. Home Address
   Street
   City
   County
   Zip

## 3. Governing Body
   (Area Code) Telephone

## 4. Home Address
   Street
   City
   County
   Zip

## 5. Type of Ownership
- Individual
- Corporation
- Non-Profit
- Partnership
- Church
- Government
- Other

## 6. Registered Agent for Service (for Corporation)

## 7. Attach the Director & Owner Survey Form.

## 8. Indicate if you have previously owned and operated an Adult Day Center
- No
- Yes
   IF YES, please indicate in space #14 where you previously operated a center.

## 9. Requested Capacity (specific # of participants)

## 10. Center or Governing Body E-mail Address

## 11. Change in Capacity
   From
   To

## 12. Previous Governing Body

## 13. Previous Center Name

## 14. Previous Center Address

## 15. The above information is true and correct to the best of my knowledge. I understand that submitting false information may result in denial of my application pursuant to O.C.G.A. § 31-2-8(c)

Print Name of Owner

Date

Signature of Owner

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*Submission of the application is subject to approval by the Department. Operating an adult day center without a license is prohibited.*
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:
# ADMINISTRATOR & OWNER SURVEY FORM

Name of Facility: _________________________________________________  County: __________________________

Mailing Address: ________________________________________  City: ____________________  Zip: _____________

| NAME OF ADMINISTRATOR | DATE OF BIRTH | SOCIAL SECURITY # | ALSO OWNER?  
|------------------------|--------------|--------------------|--------------
|                        |              |                    | Yes / No     |

<table>
<thead>
<tr>
<th>NAME OF OWNER(S)</th>
<th>ADDRESS</th>
<th>TELEPHONE NUMBER</th>
<th>PERCENTAGE OWNERSHIP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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Owner’s Signature: ____________________________________________  Date: ____________________________

01/01/2012
Water and Septic Tank Report Form

Water and sewage systems must meet applicable federal, state and local standards or regulations. This report form should be completed by the County Environmentalist from the County Public Health Department in which the facility is located if the community is served by a well and/or a septic tank. **If the community is served by public water and sewer, you only need to submit a copy of a current water bill.**

To be completed by applicant:

Facility Name: ________________________________________________

Address: ____________________________ City: ______________________

County: ____________________________ Telephone: __________________

To be completed by the County Environmentalist:

WATER (check only one):

______ The facility’s water supply is from an approved source.

______ The facility’s well has been tested and the report is attached.

SEWAGE (check only one):

______ The facility is connected to a public or community sewage disposal system.

______ The facility is served by an on-site sewage system adequate for the proposed use for ________________________________ residents.

Maximum Number of Residents

County Environmentalist: ____________________________ Print Name ____________________________ Title

Signature: __________________________________ Date: ____________________________

02/01/2012
### SCHEDULE OF LICENSURE ACTIVITY FEES

<table>
<thead>
<tr>
<th>Licensure Activity</th>
<th>Fee</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Application Processing Fees:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• New Application</td>
<td>$300</td>
<td>Upon submission</td>
</tr>
<tr>
<td>• Change of Ownership</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Change in Service Level (Requiring on site visit)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Name Change</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Initial License Fee</strong></td>
<td>Varies by program</td>
<td>Submitted prior to issuance of license</td>
</tr>
<tr>
<td>(Same an annual licensure activity fee for each program type)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Involuntary Application Processing fee subsequent to unlicensed complaint investigation</strong></td>
<td>$550</td>
<td></td>
</tr>
<tr>
<td><strong>Follow-up visit to periodic inspection</strong></td>
<td>$250</td>
<td>License renewal date</td>
</tr>
</tbody>
</table>

### LICENSES

- **Adult Day Centers**
  - Social Model: $250, Annually
  - Medical Model: $350, Annually

- **Ambulatory Surgical Treatment Centers (ASC)***: $750, Annually

- **Assisted Living Communities (ALC)**
  - 25 to 50 beds: $750, Annually
  - 51 or more beds: $1,500, Annually

- **Birthing Centers**: $250, Annually

- **Clinical Laboratories***: $500, Annually

- **Community Living Arrangements*(CLA)**: $350, Annually

- **Drug Abuse Treatment Programs* (DATEP)**: $500, Annually

- **End Stage Renal Disease Centers (ESRD)**
  - 1 – 12 stations: $600, Annually
  - 13 - 24 stations: 1,000, Annually
  - 25 or more stations: $1,100, Annually

- **Stand Alone ESRD Facilities Offering Peritoneal Dialysis Only**: $800, Annually

- **Eye Banks**: $250, Annually

- **Home Health Agencies* (HHA)**: $1,000, Annually

- **Hospices* (HSPC)**: $1,000, Annually

- **Hospitals**
  - 1 to 24 beds: $250, Annually
  - 25 to 50 beds: $750, Annually
  - 51 or more beds: $1,500, Annually

- **ICFMRs - Intermediate Care Facilities / MR (private)**: $250, Annually

- **Narcotic Treatment Programs (NTP)**: $1,500, Annually

- **Memory Care Certificate** for Assisted Living/Personal Care Homes: $200, Annually

- **Nursing Homes**
  - 1 to 99 beds: $500, Annually
  - 100 or more beds: $750, Annually

- **Personal Care Homes (PCH)**
  - 2 to 24 beds: $350, Annually
  - 25 to 50 beds: $750, Annually
  - 51 or more beds: $1,500, Annually
<table>
<thead>
<tr>
<th>Private Home Care Providers*(PHCP)</th>
<th>Per Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Companion Sitting</td>
<td>$250</td>
</tr>
<tr>
<td>Personal Care Services</td>
<td>$250</td>
</tr>
<tr>
<td>Nursing Services</td>
<td>$250</td>
</tr>
<tr>
<td>Traumatic Brain Injury Facilities</td>
<td>$250</td>
</tr>
<tr>
<td>X-ray Registration</td>
<td>$300</td>
</tr>
</tbody>
</table>

**MISCELLANEOUS FEES**

<table>
<thead>
<tr>
<th>Fee Description</th>
<th>Fee</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Civil monetary penalties as finally determined</td>
<td></td>
<td>Case-by-case basis</td>
</tr>
<tr>
<td>Late Fee – 60 days past due</td>
<td>$150</td>
<td>Per instance</td>
</tr>
<tr>
<td>Permit replacement</td>
<td>$50</td>
<td>Per request</td>
</tr>
<tr>
<td>List of Facilities by license type (electronic only)</td>
<td>$25</td>
<td>Per request</td>
</tr>
</tbody>
</table>

**ACCREDITATION DISCOUNT INFORMATION**

*Eligible for a 25% discount if currently accredited by a nationally recognized accreditation organization approved by the department as having standards comparable to specific state licensure requirements and a complete copy of the current decision is submitted to the department at the time of annual license fee renewal. Currently the department will accept current accreditation at the level Medicare (CMS) accepts for deemed status from a CMS approved organization. Below is the list of the current accreditation organizations approved by this department.*

<table>
<thead>
<tr>
<th>Accreditation Organization</th>
<th>Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accreditation Association for Ambulatory Health Care (AAAHC)</td>
<td>Ambulatory Surgery</td>
</tr>
<tr>
<td>Accreditation Commission for Health Care, Inc (ACHC)</td>
<td>CLA, HHA, Hospice, PHCP</td>
</tr>
<tr>
<td>American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)</td>
<td>Ambulatory Surgery</td>
</tr>
<tr>
<td>American Osteopathic Association Healthcare Facilities Accreditation Program (AOA/HFAP)</td>
<td>CAH, ASC, Hospital</td>
</tr>
<tr>
<td>American Association for Blood Banks (AABB)</td>
<td>Clinical Laboratory</td>
</tr>
<tr>
<td>American Society for Histocompatibility and Immunogenetics (ASHI)</td>
<td>Clinical Laboratory</td>
</tr>
<tr>
<td>Center for Improvement in Healthcare Quality (CIHQ)</td>
<td>Hospital</td>
</tr>
<tr>
<td>Commission on the Accreditation of Rehabilitation Facilities (CARF)</td>
<td>CLA, DATEP, PHCP</td>
</tr>
<tr>
<td>COLA</td>
<td>Clinical Laboratory</td>
</tr>
<tr>
<td>College of American Pathologists (CAP)</td>
<td>Clinical Laboratory</td>
</tr>
<tr>
<td>Community Health Accreditation Program (CHAP)</td>
<td>Hospice, PHCP</td>
</tr>
<tr>
<td>Council on Accreditation (COA)</td>
<td>CLA, DATEP</td>
</tr>
<tr>
<td>Council on Quality and Leadership (CQL)</td>
<td>CLA, DATEP, PHCP</td>
</tr>
<tr>
<td>Det Norske Veritas Healthcare (DNV Healthcare)</td>
<td>CAH, Hospital</td>
</tr>
<tr>
<td>The Joint Commission (JC)</td>
<td>ASC, CAH, CLA, Clinical Laboratory, DATEP, HHA, Hospice, Hospital, PHCP</td>
</tr>
</tbody>
</table>
ANNUAL LICENSE RENEWAL PAYMENTS

The Rules and Regulations for General Licensing and Enforcement Requirements, Chapter 111-8-25, require licensed providers to pay licensure activity fees annually. The department no longer mails annual licensing fee invoices. **The annual fees are due October 31st and collected through December 31st each year without penalty.** A late fee of $150 is automatically added to your balance on January 1st each year.

**A new and simplified way to view and understand annual fees:**

Fees paid between October and December 31st are good for the following calendar year. For example, if your annual fees are current, fees paid in November 2021 are good for Calendar year 2022.

Regardless of when your initial licensing fee was paid, the payment is good for that calendar year. For example, if you pay your initial license fee in June and are licensed in August 2021- The initial license fee is good for calendar year 2021. The renewal fee due in October 2021 is for calendar year 2022.

**How and where to pay annual licensing fees:**

You must pay your annual licensing fees in our payment web portal. This link is permanently located on the Healthcare Facility Regulation Home page. Here is the direct link for your convenience. https://forms.dch.georgia.gov/Forms/Payments

The department accepts Visa, Mastercard, Discover and American Express. ACH payments are also accepted using your checking account.

**Licensure activity fees collected by the department are NOT REFUNDABLE.**

If you have questions regarding annual licensing activity fees, please send your inquiry to:

HFRD.payments@dch.ga.gov