

## 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](mailto: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](mailto: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**
- |   |   |
|---|---|
| <input type="radio"/> New Permit<br><input type="radio"/> Change of Governing Body (ownership)<br><input type="radio"/> Change of Center's Name | <input type="radio"/> Change of Address (not location)<br><input type="radio"/> Change of Capacity<br><input type="radio"/> Adult Day Care <input type="radio"/> Adult Day Health |
|---|---|

1. Name of Center	(Area Code) Telephone
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2. Home Address	Street	City	County	Zip
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3. Governing Body	(Area Code) Telephone
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4. Home Address	Street	City	County	Zip
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5. Type of Ownership	<input type="radio"/> Individual	<input type="radio"/> Corporation	<input type="radio"/> Non-Profit	<input type="radio"/> Partnership
	<input type="radio"/> Church	<input type="radio"/> Government	<input type="radio"/> 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
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11. Change in Capacity From                      To	12. Previous Governing Body
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13. Previous Center Name	14. Previous Center Address
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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 \_\_\_\_\_

***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
NAME OF OWNER(S)	ADDRESS	TELEPHONE NUMBER	PERCENTAGE OWNERSHIP

Owner's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## 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.**

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### To be completed by applicant:

Facility Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

County: \_\_\_\_\_ Telephone: \_\_\_\_\_

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### 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: \_\_\_\_\_



## SCHEDULE OF LICENSURE ACTIVITY FEES

Licensure Activity	Fee	Frequency
Application Processing Fees: <ul style="list-style-type: none"> <li>New Application</li> <li>Change of Ownership</li> <li>Change in Service Level (Requiring on site visit)</li> <li>Name Change</li> </ul>	\$300	Upon submission
Initial License Fee (Same as annual licensure activity fee for each program type)	Varies by program	Submitted prior to issuance of license
Involuntary Application Processing fee subsequent to unlicensed complaint investigation	\$550	
Follow-up visit to periodic inspection	\$250	License renewal date
<b>LICENSES</b>		
<b>Adult Day Centers</b>		
Social Model	\$250	Annually
Medical Model	\$350	Annually
<b>Ambulatory Surgical Treatment Centers (ASC)*</b>	\$750	Annually
<b>Assisted Living Communities (ALC)</b>		
25 to 50 beds	\$750	Annually
51 or more beds	\$1,500	Annually
<b>Birthing Centers</b>	\$250	Annually
<b>Clinical Laboratories*</b>	\$500	Annually
<b>Community Living Arrangements*(CLA)</b>	\$350	Annually
<b>Drug Abuse Treatment Programs* (DATEP)</b>	\$500	Annually
<b>End Stage Renal Disease Centers (ESRD)</b>		
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
<b>Eye Banks</b>	\$250	Annually
<b>Home Health Agencies*(HHA)</b>	\$1,000	Annually
<b>Hospices*(HSPC)</b>	\$1,000	Annually
<b>Hospitals*</b>		
1 to 24 beds	\$250	Annually
25 to 50 beds	\$750	Annually
51 or more beds	\$1,500	Annually
<b>ICFMRs - Intermediate Care Facilities / MR (private)</b>	\$250	Annually
<b>Narcotic Treatment Programs (NTP)</b>	\$1,500	Annually
<b>Memory Care Certificate</b> for Assisted Living/Personal Care Homes	\$200	Annually
<b>Nursing Homes</b>		
1 to 99 beds	\$500	Annually
100 or more beds	\$750	Annually
<b>Personal Care Homes (PCH)</b>		
2 to 24 beds	\$350	Annually
25 to 50 beds	\$750	Annually
51 or more beds	\$1,500	Annually

<b>Private Home Care Providers*(PHCP)</b>	Per Service	
Companion Sitting	\$250	Annually
Personal Care Services	\$250	Annually
Nursing Services	\$250	Annually
<b>Traumatic Brain Injury Facilities</b>	\$250	Annually
<b>X-ray Registration</b>	\$300	Initial Application Only
<b>MISCELLANEOUS FEES</b>		
Civil monetary penalties as finally determined		Case-by-case basis
Late Fee – 60 days past due	\$150	Per instance
Permit replacement	\$50	Per request
List of Facilities by license type (electronic only)	\$25	Per request
<b>ACCREDITATION DISCOUNT INFORMATION</b>		
<p><b>*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.</b></p>		
<b>Accreditation Organization</b>	<b>Program</b>	
Accreditation Association for Ambulatory Health Care (AAAH)	Ambulatory Surgery	
Accreditation Commission for Health Care, Inc (ACHC)	CLA, HHA, Hospice, PHCP	
American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)	Ambulatory Surgery	
American Osteopathic Association Healthcare Facilities Accreditation Program (AOA/HFAP)	CAH, ASC, Hospital	
American Association for Blood Banks (AABB)	Clinical Laboratory	
American Society for Histocompatibility and Immunogenetics (ASHI)	Clinical Laboratory	
Center for Improvement in Healthcare Quality (CIHQ)	Hospital	
Commission on the Accreditation of Rehabilitation Facilities (CARF)	CLA, DATEP, PHCP	
COLA	Clinical Laboratory	
College of American Pathologists (CAP)	Clinical Laboratory	
Community Health Accreditation Program (CHAP)	Hospice, PHCP	
Council on Accreditation (COA)	CLA, DATEP	
Council on Quality and Leadership (CQL)	CLA, DATEP, PHCP	
Det Norske Veritas Healthcare (DNV Healthcare)	CAH, Hospital	
The Joint Commission (JC)	ASC, CAH, CLA, Clinical Laboratory, DATEP, HHA, Hospice, Hospital, PHCP	

## 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 31<sup>st</sup> and collected through December 31<sup>st</sup> each year without penalty.*** A late fee of \$150 is automatically added to your balance on January 1<sup>st</sup> each year.

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

Fees paid between October and December 31<sup>st</sup> 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](mailto:HFRD.payments@dch.ga.gov)