HOME HEALTH AGENCY 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 the Home Health Agency (HHA) application packet. As a reminder, all policies and procedures must be established as part of the requirements for regulations and readily available upon request.

Upon application submission and payment, if required, you will receive an acknowledgement email. Applications are reviewed in the order they are received by our office. The initial review timeframe is ***30 business days*** from the application submission date.

The official rules for Home Health Agencies are on record with the Georgia Secretary of State's Office at http://rules.sos.state.ga.us/.

The online application portal can be accessed at https://gahles.dch.georgia.gov/. All correspondence regarding the status of your application will be sent to the email address provided for the contact person on your application. If additional documentation is required, you will receive an email from HFRD_do_not_reply@dch.ga.gov containing a link to the application portal and a verification code. Please open the email, copy the invitation code, and paste it into the provided link to check your application status. Upload the requested documents, confirm that all documents have been uploaded, and click submit. You will receive a confirmation email acknowledging that we have received your documents. Failure to upload the requested documents will result in the denial of your application.

For information regarding Change of Ownership (CHOW), review Frequently Asked Questions on DCH website - https://dch.georgia.gov/divisionsoffices/hfrd/facilities-provider-information/hfrd-chow-faq .

For questions regarding HHA Regulations, surveys, plan of corrections, permits, facility letters, administrator and/or contact information update, i.e., email address, phone numbers, email the Home Care Team at hfrd.hospicehh@dch.ga.gov .

For general application questions, email the HFRD Applications and Waivers Team at hfrd.applicationswaivers@dch.ga.gov .

Note: Application fees are non-refundable. All licensure fees must be paid in full prior to receiving a permit or license. The licensure fee will be collected by the program after the application review is complete. If you encounter payment issues during the application process, email the Finance Team at hfrd.payments@dch.ga.gov for assistance.

Initial

1. Certificate of Need approval from GA Department of Community Health, Office of Health Planning (OHP) Rule 111-8-31-.03 Certificate of Need Review. "**Have you obtained the Certificate of Need (CON) approval from DCH Office of Health Planning**?" If "yes", proceed with the application submission. If "no", the application cannot be completed at this time. For more information, visit DCH OHP website at https://dch.georgia.gov/con-applications-and-forms .
2. Notarized Affidavit of Personal Identification
3. Copy of photo ID that was shown to the notary public
4. Notarized Affidavit of Compliance **(select Home Health Agencies)**
5. Complete the electronic Owner Form. List all individual owners if applicable. This form must be

signed and dated by the Owner.
6. **Satisfactory determination letter, dated within 12 months of the application submission date**, from the DCH Georgia Criminal History Check System (GCHEXS). All administrators and individual owners with 10% or more ownership interest must complete a fingerprint-based background check through GCHEXS. The owner of the facility may request access to GCHEXS by going to GCHEX. For Fingerprint Background Check rules and regulations, visit the Secretary of State website at 111-8-12. For additional information, please visit **DCH OIG**, or by calling at 404-463-7154 or by emailing at gchexs.user@dch.ga.gov .
Note: If there are no individuals that own 10% or more interest, provide a letter on company letterhead stating this information. The letter must be signed by the owner or owner representative.
7. Copy of Business License from local city/county government. The business license must be current with the facility name and address. If you are unable to obtain a business license, provide a written explanation from your local government stating the reason.
8. Evidence from Georgia Secretary of State that the corporation, LLC, etc. is registered, if applicable. If not applicable, provide other supporting documentation showing legal authority.
9. Copy of organizational chart and policies and procedures regarding administrative control, lines of authority, and scope of services provided. **Rule 111-8--31- .07(1)**
10. Policies that define the scope of services provided by the agency. **Rule 111-8--31- .07(1)**
11. Policy regarding the role of the Governing Body/Board of Directors. Name and address for each board member and owner(s). **Rule 111-8-31-.07(2)**
12. Home Health budget plan for 1st year.
13. Description of composition and responsibilities of a group of professional personnel (i.e., policy or procedure). Must contain all required members including but not limited to MD, Admin, DON, HHA, Medical SW and RN. **Rule 111-8-31-.07 (3)(a & b)**
Note: Responsibilities include establishing an annual review of policies, quarterly meetings with documentation of meeting minutes, participation in evaluation of agency's program, and assist in maintaining liaison with community.
14. Name, qualifications, and signed job description, (including professional license, if applicable) of administrator. Meets qualification requirements of either: Licensed physician or Licensed registered nurse; or has training and experience in health service administration and at least one (1) year of supervisory or administrative experience in home health care or related health programs.

Job duties/responsibilities include:

- Ensures responsibility and accountability for organizing and directing the agency's ongoing functions.
- Maintains ongoing liaison among the Governing Body, group of professional personnel, and the staff.
- Ensures employment of qualified staff.
- Ensures adequate staff education and evaluations.
- Ensures the accuracy of public information, materials, and activities.
- Ensures the implementation of an effective budgeting and accounting system.

15. Policy regarding delegation of authority in the absence of the administrator. **Rule 111-8-31-.07(5)**
16. Policies regarding personnel practices, including contract personnel. **Rule 111-8-31-.07(6)**
Names, qualifications, and signed job descriptions, for all staff members and contract personnel, including current licenses where applicable and health examinations.
17. Copies of any contracts for hourly or per-visit personnel.

18. Name, qualifications, signed job description, and evidence of current license for the supervisor/director of nursing services.
19. HHS 690 Assurance of Compliance https://ocrportal.hhs.gov/ocr/aoc/instruction.jsf
20. CMS 1561 Health Insurance Benefit Agreement
21. Licensure fee - see Schedule of Licensure Activity Fees
https://dch.georgia.gov/divisionsoffices/hfrd/hfrd-payment-portal

Change of Ownership (CHOW)

1. Evidence from Georgia Secretary of State that the corporation, LLC, etc. is registered, if applicable. If not applicable, provide other supporting documentation showing legal authority.
2. Copy of the executed legal transaction documents for the business entity (Bill of Sale, closing documents, etc.). This document must be signed by the previous governing body/owner and disclose the effective date of change of ownership/closing.

Note: While the sale is pending, the CHOW application can be submitted and note that the bill of sale will be submitted when the sale is completed. This will allow HFR to start the review process prior to the ownership change.

3. Organizational charts of the ownership structure for the governing body pre- and post-sale transaction.
4. Copy of Business License from local city/county government. The business license must be current with the facility name and address. If you are unable to obtain a business license, provide a written explanation from your local government stating the reason.
5. Notarized Affidavit of Personal Identification
6. Copy of photo ID that was shown to the notary public
7. Complete the electronic Owner Form. List all individual owners if applicable. This form must be signed and dated by the Owner.
8. **Satisfactory determination letter, dated within 12 months of the application submission date**, from the DCH Georgia Criminal History Check System (GCHEXS). All administrators and individual owners with 10% or more ownership interest must complete a fingerprint-based background check through GCHEXS. The owner of the facility may request access to GCHEXS by going to GCHEX. For Fingerprint Background Check rules and regulations, visit the Secretary of State website at 111-8-12. For additional information, please visit **DCH OIG**, or by calling at 404-463-7154 or by emailing at gchexs.user@dch.ga.gov .

Note: If there are no individuals that own 10% or more interest, provide a letter on company letterhead stating this information. The letter must be signed by the owner or owner representative.

9. HHS 690 Assurance of Compliance https://ocrportal.hhs.gov/ocr/aoc/instruction.jsf
10. CMS 1561 Health Insurance Benefit Agreement

Branch Addition

1. Certificate of Need approval from GA Department of Community Health, Office of Health Planning (OHP).
2. Notarized Affidavit of Personal Identification
3. Copy of photo ID that was shown to the notary public
4. Provide a letter on business letterhead indicating the parent agency the branch will be billing under and the counties the branch will be servicing. If the branch serves counties currently not authorized under the parent agency, list the additional counties.
5. Google map showing distance from main agency address to each county being serviced

Branch Removal

1. Notarized Affidavit of Personal Identification
2. Copy of photo ID that was shown to the notary public
3. Provide a letter on business letterhead indicating the branch location that will be removed.

Change in Service (add)

1. Notarized Affidavit of Personal Identification
2. Copy of photo ID that was shown to the notary public
3. Provide a letter on business letterhead requesting the type of service(s) that will be added

Change in Service (remove)

1. Notarized Affidavit of Personal Identification
2. Copy of photo ID that was shown to the notary public
3. Provide a letter on business letterhead requesting the type of service(s) that will be removed

Facility Name Change

1. Notarized Affidavit of Personal Identification
2. Copy of photo ID that was shown to the notary public
3. Provide a letter on business letterhead explaining the change and the effective date.

Governing Body Name Change (not a CHOW)

1. Provide a letter on business letterhead explaining the change and the effective date.
2. Notarized Affidavit of Personal Identification
3. Copy of photo ID that was shown to the notary public
4. Evidence from Georgia Secretary of State that the corporation, LLC, etc. is registered, if applicable. If not applicable, provide other supporting documentation showing legal authority.

Relocation

1. Certificate of Need approval from GA Department of Community Health, Office of Health Planning (OHP).
2. Notarized Affidavit of Personal Identification
3. Copy of photo ID that was shown to the notary public
4. Provide a letter on business letterhead explaining if this will impact the current patients being served. If so, please provide a plan that shows how the agency will accommodate the patient(s).
5. Google map showing distance from main agency address to each county being serviced

Service Area Change (add counties)

1. Certificate of Need approval from GA Department of Community Health, Office of Health Planning (OHP).
2. Notarized Affidavit of Personal Identification
3. Copy of photo ID that was shown to the notary public
4. Provide a letter on business letterhead indicating the counties they currently serve, and the counties they want to add.
5. Provide a letter on business letterhead explaining if this change will impact current patients being served. If so, please provide a plan that shows how the agency will accommodate the patient(s).
6. Google map showing distance from main agency address to each county being serviced

Service Area Change (remove counties)

1. Certificate of Need approval from GA Department of Community Health, Office of Health Planning

(OHP).
2. Notarized Affidavit of Personal Identification
3. Copy of photo ID that was shown to the notary public
4. Provide a letter on business letterhead indicating the counties they currently serve, and the counties that will be removed
5. Provide a letter on business letterhead explaining if this change will impact current patients being served. If so, please provide a plan that shows how the agency will accommodate the patient(s).

O.C.G.A. § 50-36-1(f)(1)(B) 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:

_____ I am a United States citizen.

_____ I am a legal permanent resident of the United States.

_____ 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(f)(1)(A), 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:

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Brian P. Kemp, Governor **Dean Burke, MD, Commissioner**

2 Martin Luther King Jr. Dr. SE, East Tower, 17th fl. | Atlanta, GA 30334 | 404-657-5700 | www.dch.georgia.gov

AFFIDAVIT OF COMPLIANCE

I, _____, the undersigned duly authorized representative of
Name of Owner/Applicant

_____, hereby attest that in furtherance of its application
Governing Body Name

for licensure, said entity has developed policies and procedures mandated under the rules and regulations indicated below. If the application for licensure is approved by the Department, these policies and procedures shall be implemented immediately by the facility. Additionally, _____ understands that once licensed, it is
Governing Body Name

subject to unannounced periodic inspections at which time the policies and procedures shall be readily available for review for sufficiency and compliance with applicable rules and regulations. Deficient policies and procedures may subject the facility to sanctions pursuant to Ga. Comp. R. & Regs. 111-8-25.

1) _____ Assisted Living Communities
Chapter 111-8-63

2) _____ Home Health Agencies
Chapter 111-8-31

3) _____ Hospices
Chapter 111-8-37

4) _____ Narcotic Treatment Programs
Chapter 111-8-53

5) _____ Personal Care Homes
Chapter 111-8-62

6) _____ Private Home Care Providers
Chapter 111-8-65

This _____ day of _____, 20___.

_____
Signature of Authorized Representative

_____
Business/Facility Name

SUBSCRIBED AND SWORN
BEFORE ME ON THIS THE
___DAY OF_____20_____

_____
NOTARY PUBLIC
My Commission Expires: