Intermediate Care Facility/Individuals with Intellectual Disabilities (ICF/IID)
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 Intermediate Care Facility/Individuals with Intellectual Disabilities 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 Intermediate Care Home (ICF/IID) 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 Intermediate Care Home Regulations, surveys, plan of corrections, permits, facility letters, administrator and/or contact information update, i.e., email address, phone numbers, email the Specialized Care Team at hfrd.specialized@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. 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. Notarized Affidavit of Personal Identification
3. Copy of photo ID that was shown to the notary public
4. A copy of proof of ownership/legal control of the property (deed, lease, or bill of sale)
5. Complete the electronic Owner Form. List all individual owners if applicable. This form must be signed

and dated by the owner or the owner's representative.
6. Georgia State Fire Safety approval for the requested bed count
7. A letter from the physician and dentist who have agreed to provide emergency service, and the names of the administrator and supervisor of care shall accompany the application.
8. ICF/IDD and Hospital Patient Transfer Agreement
9. Proof of liability insurance or a self-insurance trust
10. **New buildings**: submit a copy of the floor plan with the bed breakdown.
Existing buildings: include the floor plan only if changes have been made to the previous floor plan.

Will the facility participate in the Federal Medicare and Medicaid Program? Yes _____ No _____
If yes, provide Items #11 through #14. If no, skip to Item #16.

Please submit the underlined federal forms directly to: hfrd.specialized@dch.ga.gov
11. CMS 671 LTC Facility Application for Medicare / Medicaid
12. CMS 1561 Health Insurance Benefit Agreement
13. HHS 690 Assurance of Compliance /Civil Rights https://ocrportal.hhs.gov/ocr/aoc/instruction.jsf
14. CMS 3070G ICF/IID Deficiency Report
15. CMS 855A approval letter is required. This letter is issued directly to the Department of Community Health (DCH) by the Medicare Administrative Contractor (MAC); therefore, it should not be uploaded.
16. 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. Notarized Affidavit of Personal Identification
3. Copy of photo ID that was shown to the notary public
4. A copy of proof of ownership/legal control of the property (deed, lease, or bill of sale)
5. Complete the electronic Owner Form. List all individual owners if applicable. This form must be signed and dated by the owner or the owner's representative.
6. 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.
7. ICF/IDD and Hospital Patient Transfer Agreement
8. Proof of liability insurance or a self-insurance trust for the new owner

Will the facility participate in the Federal Medicare and Medicaid Program? Yes _____ No _____
If yes, provide Items #9 through #12. If no, skip to Item #13.

Please submit the underlined federal forms directly to: hfrd.specialized@dch.ga.gov
9. CMS 671 LTC Facility Application for Medicare / Medicaid
10. CMS 1561 Health Insurance Benefit Agreement
11. HHS 690 Assurance of Compliance /Civil Rights https://ocrportal.hhs.gov/ocr/aoc/instruction.jsf
12. CMS 3070G ICF/IID Deficiency Report
13. CMS 855A **approval letter** is required. This letter is issued directly to the Department of Community

Health (DCH) by the Medicare Administrative Contractor (MAC); therefore, it should not be uploaded.

Relocation

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. Notarized Affidavit of Personal Identification
3. Copy of photo ID that was shown to the notary public
4. A copy of proof of ownership/legal control of the property (deed, lease, or bill of sale)
5. Georgia State Fire Safety approval for the requested bed count
6. Proof of liability insurance or a self-insurance trust
7. Provide a copy of the facility floor plan

Facility Name Change

1. Notarized Affidavit of Personal Identification
2. Copy of photo ID that was shown to the notary public
3. If participating in the Federal Medicare and Medicaid Programs - CMS 855A **approval letter** is required. This letter is issued directly to the Department of Community Health (DCH) by the Medicare Administrative Contractor (MAC); therefore, it should not be uploaded.

If no, there are no additional documents required.

Governing Body Name Change (not a 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. Notarized Affidavit of Personal Identification
3. Copy of photo ID that was shown to the notary public
4. If participating in the Federal Medicare and Medicaid Programs - CMS 855A **approval letter** is required. This letter is issued directly to the Department of Community Health (DCH) by the Medicare Administrative Contractor (MAC); therefore, it should not be uploaded.

If no, there are no additional documents required.

Increase in Bed Capacity

1. Notarized Affidavit of Personal Identification
2. Copy of photo ID that was shown to the notary public
3. Georgia State Fire Safety approval for the requested bed count
4. Provide a copy of the facility floor plan that indicates where the additional beds are located and the location of any building construction or renovation.

Decrease in Bed Capacity

1. Notarized Affidavit of Personal Identification
2. Copy of photo ID that was shown to the notary public

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: