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 time frame 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/. A courtesy copy of the rules for Intermediate Care Home (ICF/IID) can be found on Healthcare Facility Regulation Division website at https://dch.georgia.gov/divisionsoffices/healthcare-facility-regulation/hfr-laws-regulations .

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.applicationswaivers@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. A confirmation email will be sent, indicating that your documents will be reviewed within 14 business days. 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 and surveys, email 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.

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. Georgia State Fire Safety approval for the requested bed count

6. 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.

7. Nursing Home/Hospital Patient Transfer Agreement

8. Proof of liability insurance or a self-insurance trust

9. **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 #10 through #14, if not, skip to Item #15:

10. CMS 671 - LTC Facility Application for Medicare/Medicaid (See the CMS website)

11. CMS 1561 - Health Insurance Benefits Agreement

12. Copy of the Assurance of Compliance HHS 690 electronic confirmation letter

**The Dept. of Health and Human Services Assurance of Compliance (HHS 690) use the online web portal at: https://ocrportal.hhs.gov/ocr/aoc/aocContact.jsf **

13. CMS 855A and approval letter (required upon application submission)

14. CMS 3070G ICF/IID Deficiency Report (required upon application submission)

15. Licensure fee (see Schedule of Licensure Activity Fees)

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.
If a non-profit - include documentation of non-profit status [501(c) 3]
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. 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.

6. Nursing Home/Hospital Patient Transfer Agreement
7. Proof of liability insurance or a self-insurance trust for the new owner
8. **Capacity Increase?** Yes _____ No _____

If yes, then please provide the following additional documentation:

a) Certificate of Need that indicates the number of beds approved by the DCH Office of Health Planning. For more information, visit DCH OHP website at: https://dch.georgia.gov/divisionsoffices/office-health-planning .
b) Georgia State Fire Safety approval for the requested bed count
c) Floor Plan that indicates where the additional beds are located and the location of any building construction or renovation.

Will the facility participate in the Federal Medicare and Medicaid Program? Yes _____No _____

If yes, provide Items #9 through #13:

9. CMS 671 - LTC Facility Application for Medicare/Medicaid (See the CMS website)
10. CMS 1561 – Health Insurance Benefits Agreement
11. Copy of the Assurance of Compliance HHS 690 electronic confirmation letter

**The Dept. of Health and Human Services Assurance of Compliance (HHS 690) use the online web portal at: https://ocrportal.hhs.gov/ocr/aoc/aocContact.jsf **

12. CMS 855A and approval letter (required upon application submission)
13. CMS 3070G ICF/IID Deficiency Report (required upon application submission)

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 for the new owner
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

Governing Body Name Change (not a change of ownership)

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

Capacity Increase

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.

Capacity Decrease

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:

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(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 this the ____day of _____, 20 ___ 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

Schedule of Licensure Activity Fees

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

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

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
Private Home Care Providers*(PHCP)	Per Service	
Companion Sitting	$250	Annually
Personal Care Services	$250	Annually
Nursing Services	$250	Annually
Traumatic Brain Injury Facilities	$250	Annually
X-ray Registration	$300	Initial Registration Only

MISCELLANEOUS FEES

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
Returned Check Charge- as assessed by bank	< $50	Per instance

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.**

Accreditation Organization	Program
Accreditation Association for Ambulatory Health Care (AAAHC)	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
Center for Improvement in Healthcare Quality (CIHQ)	Hospital
Commission on the Accreditation of Rehabilitation Facilities (CARF)	CLA, DATEP, PHCP
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, DATEP, HHA, Hospice, Hospital, PHCP