PERSONAL CARE HOME 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 Personal Care Home Application Packet. As a reminder, all policies and procedures must be established as part of the requirements 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 Personal Care Homes 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 Personal Care Homes 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 additional documentation is requested, you will receive an email from workflow@dch.ga.gov. **Please open the email from workflow@dch.ga.gov , click on the link at the bottom of the email or copy and paste the entire link in browser, and upload the requested documents.** Please continue to monitor your email, including your Junk/Spam folder for emails from workflow@dch.ga.gov .

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

For general application questions, email hfrd.applicationswaivers@dch.ga.gov .

For questions regarding PCH Rules and Regulations and facility closures, email pchprogram.hfrd@dch.ga.gov .

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 personal care home
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 personal care home
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. Notarized Affidavit of Personal Identification **and** copy of ID that was shown to the notary public

4. A copy of Proof of Ownership for the property or a copy of the Lease Agreement

5. Fire Safety Inspection Report with no violations or hazards identified from the appropriate fire safety authority showing capacity load (must be dated within 12 months of application submission). A sprinkler system is required for 7 beds or more.

6. Electrical Inspection Compliance Form with no violations or hazards identified from a Georgia licensed electrician and the electrician's State license number (must be dated within 6 months of application submission)

7. Floor Sketch (label all rooms, bedroom measurements, location of all doors, windows and bed placement for residents, provider's personal living quarters, and staff)

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

9. Completed fingerprinting through Georgia Criminal Background Check System (GCHEXS) for all administrators and individual owners with 10% or more ownership (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-backgroundcheck-system-gchexs/georgia-criminal-background-check-system-gchexs .
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.

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

11. A Letter of Determination approved by the Office of Health Planning (OHP) for 25 or more beds. For more information, visit DCH-OHP website at https://dch.georgia.gov/con-applications-and-forms .

12. Notarized Affidavit of Financial Stability for 25 or more beds

13. 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 personal care home 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 personal care home
If a non-profit - include documentation of non-profit status [5O1(c) 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. Notarized Affidavit of Personal Identification **and** copy of id that was shown to the notary public

4. A copy of Proof of Ownership for the property or a copy of the Lease Agreement

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

6. Completed fingerprinting through Georgia Criminal Background Check System (GCHEXS) for all administrators and individual owners with 10% or more ownership (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-backgroundcheck-system-gchexs/georgia-criminal-background-check-system-gchexs .
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. Notarized Affidavit of Financial Stability for 25 or more beds

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 personal care home
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 personal care home
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. Notarized Affidavit of Personal Identification **and** copy of id that was shown to the notary public

Facility Name Change

1. Application - completed and signed by the **Owner**

2. Notarized Affidavit of Personal Identification **and** copy of id that was shown to the notary public

Decrease in Capacity

1. Application - completed and signed by the **Owner**

2. Notarized Affidavit of Personal Identification **and** copy of id that was shown to the notary public

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, bedroom measurements, location of all doors, windows and bed placement for residents, family, and staff)

4. Notarized Affidavit of Personal Identification **and** copy of id that was shown to the notary public

5. A Letter of Determination approved by the Office of Health Planning (OHP) for 25 or more beds. For more information, visit DCH-OHP website at https://dch.georgia.gov/con-applications-and-forms .

Conversion from ALC to PCH

1. Application - completed and signed by the Owner
2. Notarized Affidavit of Personal Identification **and** copy of id that was shown to the notary public
3. Licensure fee is required. For more information, see Schedule of Licensure Activity Fees.

Conversion from CLA to PCH

1. Application - completed and signed by the Owner
2. Notarized Affidavit of Personal Identification **and** copy of id that was shown to the notary public
3. Licensure fee is required. For more information, see Schedule of Licensure Activity Fees.

Memory Care Certification

Before you apply for a memory care certification, you must have a Personal Care Home permit. An application form is not required. Apply in the application portal.

1. Notarized Affidavit of Personal Identification **and** copy of id that was shown to the notary public
2. Notarized Affidavit of Compliance
3. A copy of current PCH permit

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 Healthcare Facility Regulation Division
AFFIDAVIT OF FINANCIAL STABILITY

Effective July 1, 2021, required for both <u>Initial</u> Applications and CHOW Applications for Licensure for ALC and PCH of 25 beds or more (Interim Affidavit in use as of January 20, 2023.) [i]

Name of Applicant for Facility Licensure:	
Facility Address:	
Name of Certified Public Accountant (CPA):	
Business Affiliation of CPA (if applicable):	
CPA Firm License # (if applicable):	
CPA License/Certificate #:	
Mailing Address of CPA:	
Email address of CPA:	
Phone Number of CPA:	

COUNTY OF: _____

STATE OF: _____

BEFORE ME, the undersigned authority personally appeared who, being by me duly sworn, deposed as follows:

1) I have personal knowledge of the matters addressed in this affidavit the attestations made herein.

2) I am over eighteen (18) years of age, and I am of sound mind and capable of making this affidavit in support of the facts stated herein.

3) I am a Certified Public Accountant, and I am licensed in the State of _____ and my license is currently active and in good standing. My license number is _____. If I am not licensed in the State of Georgia, my firm is actively licensed with the Georgia State Board of Accountancy, and I have provided the license information above.

4) I understand and acknowledge that the above-referenced applicant for facility licensure is requesting authority from the Georgia Department of Community Health (the "Department") to operate a personal care home or assisted living community that will provide personal care services to elderly and/or disabled individuals in the State of Georgia and that there are individuals under care of the facility that may be vulnerable and in need of trustworthy oversight.

5) A☐ In executing this affidavit, I hereby swear or affirm that I have reviewed financial documents[ii] for the previous fiscal year, for the above-referenced applicant for facility licensure,

OR

B☐ In executing this affidavit, I hereby swear or affirm that, in the absence of the documents in 5A above, I have reviewed sufficient financial documents to make the required determination for the above-referenced applicant for facility licensure. Sufficient financial documents may include forward-looking documents.[iii]

6) In executing this affidavit, I hereby swear or affirm that, based on my review of the applicant's documents pursuant to 5A or 5B above, the applicant for facility licensure has demonstrated the financial resources to operate. I understand that the Department will rely on the statements made herein in making a determination regarding the applicant's eligibility for facility licensure.

_____ _____

Signature of Certified Public Accountant **Date of Signature**

_____

Printed Name of Certified Public Accountant

SUBSCRIBED AND SWORN BEFORE ME ON

THIS THE_____DAY OF_____ 20_____

Notary Public

My Commission Expires: _____

[i] Please note that the above Affidavit of Financial Stability has been modified pursuant to the Department's waiver authority in response to concerns received about language contained in the original affidavit regarding affirmation of the applicant's ability to operate as a going concern.

[ii] While this list is not exhaustive, said reviewed documents may include audited or unaudited documents such as Bank Statements, Personal Tax Returns, Business Tax Records, Invoices, Receipts, Income Statements, Balance Sheets, Profit and Loss Statements, Balance Sheets, Cash-flow Statements, Accounts Receivable/Accounts Payable, and Aging Reports.

[iii] A Pro Forma Statement or financial forecast consists of prospective financial statements that present, to the best of the applicant's knowledge and belief, an entity's expected financial position, results of operations, and cash flows. A Projected Income Statement is a snapshot of applicant's forecasted sales, cost of sales, and expenses.

PERSONAL CARE HOME APPLICATION

✓ Check All That Apply

o New Permit
o Change Governing Body (ownership)
o Change of Governing Body Name
o Change of PCH Name
o Change of Address (not location)
o Change of Capacity
o Other _____

1. Name of Home (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 o Individual o Corporation o Non-Profit o Partnership o Church o Government o Other

6. Registered Agent for Service (for Corporation)

7. Attach the Administrator & Owner Survey Form with the names, addresses, and telephone numbers of individuals or organizations having a 10% or more ownership interest in the facility.

8. Indicate if you have previously owned and operated a Personal Care Home or Community Living Arrangement o No o Yes
IF YES, please indicate in space #14 where you previously operated a home.

9. Requested Capacity (specific # of residents) 10. Facility or Governing Body E-mail Address

11. Change in Capacity
From To

12. Previous Governing Body

13. Previous PCH Name 14. Previous PCH 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) (2011).

Print Name of Owner _____ Date _____

Signature of Owner _____

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Brian P. Kemp, Governor **Caylee Noggle, Commissioner**

2 Peachtree Street, NW | Atlanta, GA 30303-3159 | 404-656-4507 | 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

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

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:

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: _____

01/01/2012

ELECTRICAL INSPECTION COMPLIANCE FORM

NAME OF COMMUNITY:_____

ADDRESS:_____

_____

OWNER:_____

OWNER'S CURRENT ADDRESS:_____

_____

OWNER'S PHONE #:_____

OWNER'S EMAIL ADDRESS:_____

- -

TO BE COMPLETED BY THE ELECTRICIAN

NOTE TO ELECTRICIAN: Do NOT complete this form unless all information is listed above regarding the location to be inspected.

I, _____ have inspected the electrical system at the above listed community and have determined that the electrical system is maintained in a safe condition and is free of hazards.

Signature:_____

Printed Name:_____

Date of Inspection:_____

Georgia State License #:_____

Phone #:_____

02/01/2012

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: _____

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 Li ense Fee (Same an 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
LICENSES		
dult Day Centers		
Social Model	$250	Annually
Medical Model	$350	Annually
mbulatory Surgical Treatment Centers (ASC)*	$750	Annually
ssisted 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 tage 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
C M s - 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

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 Application 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

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
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 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