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 your Personal Care Home (PCH) 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 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 we request additional documentation, please click on the link at the bottom of the email from 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 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 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. 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 12 months of application submission)
7. 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)

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

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

10. 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.

11. Written approval for water source and sewage disposal system (If the facility uses a septic system, complete the Water and Septic Tank Report Form)

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

13. A completed Affidavit of Financial Stability for 25 or more beds

14. 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 [501(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. 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 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.

8. A completed 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. 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.

**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

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

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**

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

**Conversion from ALC to PCH**

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. 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. 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. 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. A completed Affidavit of Personal Identification
   NOTE: Only the Affidavit in this licensure package is acceptable.

2. **Provide copy of applicant’s ID that was shown to notary**

3. A completed Affidavit of Compliance
# PERSONAL CARE HOME APPLICATION

### Check All That Apply
- New Permit
- Change Governing Body (ownership)
- Change of Governing Body Name
- Change of PCH Name
- Change of Address (not location)
- Change of Capacity
- 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
- Individual
- Corporation
- Non-Profit
- Partnership
- Church
- Government
- 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
- No
- 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 ___________________________
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:
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:
**Georgia Department of Community Health**  
**Healthcare Facility Regulation Division**  
**AFFIDAVIT OF FINANCIAL STABILITY**  
* Effective July 1, 2021, required for Initial Application for Licensure for ALC and PCH of 25 beds or more  
(Affidavit updated May 16, 2022)*

<table>
<thead>
<tr>
<th>Name of Applicant for Facility Licensure:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Address:</td>
<td></td>
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<tr>
<td>Name of Certified Public Accountant (CPA):</td>
<td></td>
</tr>
<tr>
<td>Business Affiliation of CPA (if applicable):</td>
<td></td>
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<tr>
<td>CPA Firm License # (if applicable):</td>
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<tr>
<td>CPA License/Certificate #:</td>
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<tr>
<td>Mailing Address of CPA:</td>
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<tr>
<td>Email address of CPA:</td>
<td></td>
</tr>
<tr>
<td>Phone Number of CPA:</td>
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</tr>
</tbody>
</table>

**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 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) In executing this affidavit, I hereby swear and affirm that I have reviewed the audited financial statements, for the most recently completed fiscal year, of the above-referenced applicant for facility licensure.

6) In executing this affidavit, I hereby swear and affirm that, based on my review of the audited financial statements, the above-referenced applicant for facility licensure received an unmodified or unqualified opinion and the report did not contain an emphasis of matter paragraph about the entity’s ability to continue as a going concern.

**BY: 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 SEAL]  
Notary Public

My Commission Expires: ____________________
• 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.
**ADMINISTRATOR & OWNER SURVEY FORM**

Name of Facility: _________________________________________________ County: __________________________

Mailing Address: ________________________________________ City: ____________________ Zip: _____________

<table>
<thead>
<tr>
<th>NAME OF ADMINISTRATOR</th>
<th>DATE OF BIRTH</th>
<th>SOCIAL SECURITY #</th>
<th>ALSO OWNER?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Yes / No</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>NAME OF OWNER(S)</th>
<th>ADDRESS</th>
<th>TELEPHONE NUMBER</th>
<th>PERCENTAGE OWNERSHIP</th>
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<tbody>
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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: ____________________________

02/01/2012
## SCHEDULE OF LICENSURE ACTIVITY FEES

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

### LICENSES

#### 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

#### Clinical Laboratories*

- $500  | 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

#### 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

#### Community - 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
<table>
<thead>
<tr>
<th>Private Home Care Providers*(PHCP)</th>
<th>Per Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Companion Sitting</td>
<td>$250</td>
</tr>
<tr>
<td>Personal Care Services</td>
<td>$250</td>
</tr>
<tr>
<td>Nursing Services</td>
<td>$250</td>
</tr>
<tr>
<td>Traumatic Brain Injury Facilities</td>
<td>$250</td>
</tr>
<tr>
<td>X-ray Registration</td>
<td>$300</td>
</tr>
</tbody>
</table>

**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.*

<table>
<thead>
<tr>
<th>Accreditation Organization</th>
<th>Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accreditation Association for Ambulatory Health Care (AAAHC)</td>
<td>Ambulatory Surgery</td>
</tr>
<tr>
<td>Accreditation Commission for Health Care, Inc (ACHC)</td>
<td>CLA, HHA, Hospice, PHCP</td>
</tr>
<tr>
<td>American Association for Accreditation of Ambulatory Surgery Facilities (AAAAASF)</td>
<td>Ambulatory Surgery</td>
</tr>
<tr>
<td>American Osteopathic Association Healthcare Facilities Accreditation Program (AOA/HFAP)</td>
<td>CAH, ASC, Hospital</td>
</tr>
<tr>
<td>American Association for Blood Banks (AABB)</td>
<td>Clinical Laboratory</td>
</tr>
<tr>
<td>American Society for Histocompatibility and Immunogenetics (ASHI)</td>
<td>Clinical Laboratory</td>
</tr>
<tr>
<td>Center for Improvement in Healthcare Quality (CIHQ)</td>
<td>Hospital</td>
</tr>
<tr>
<td>Commission on the Accreditation of Rehabilitation Facilities (CARF)</td>
<td>CLA, DATEP, PHCP</td>
</tr>
<tr>
<td>COLA</td>
<td>Clinical Laboratory</td>
</tr>
<tr>
<td>College of American Pathologists (CAP)</td>
<td>Clinical Laboratory</td>
</tr>
<tr>
<td>Community Health Accreditation Program (CHAP)</td>
<td>Hospice, PHCP</td>
</tr>
<tr>
<td>Council on Accreditation (COA)</td>
<td>CLA, DATEP</td>
</tr>
<tr>
<td>Council on Quality and Leadership (CQL)</td>
<td>CLA, DATEP, PHCP</td>
</tr>
<tr>
<td>Det Norske Veritas Healthcare (DNV Healthcare)</td>
<td>CAH, Hospital</td>
</tr>
<tr>
<td>The Joint Commission (JC)</td>
<td>ASC, CAH, CLA, Clinical Laboratory, DATEP, HHA, Hospice, Hospital, PHCP</td>
</tr>
</tbody>
</table>
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