TRAUMATIC BRAIN INJURY FACILITY 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 Traumatic Brain Injury (TBI) 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 may take up to 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 Traumatic Brain Injury Facilities 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 End Stage Renal Disease Facilities 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 another 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 Change of Ownership (CHOW) questions, please see Frequently Asked Questions - https://dch.georgia.gov/divisionsoffices/hfrd/facilities-provider-information/hfrd-chow-faq .

For questions regarding Traumatic Brain Injury Facilities Regulations, surveys, and permits, email hfrd.specialized@dch.ga.gov .

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

Initial

1. A completed application for a license to operate a Traumatic Brain Injury Facility, signed and dated.
2. Notarized Affidavit of Personal Identification **and** copy of ID that was shown to the notary public
3. Governing Body Documentation
4. Organizational Chart
5. Certificate of Need or Letter of Determination (https://dch.georgia.gov/divisionsoffices/office-health-planning)
6. Lease, Warranty Deed, or Bill of Sale for the property
7. Floor Plan – Label bedrooms and list the square footage measurements
8. Licensure fee is required. For more information, see Schedule of Licensure Activity Fees.

Change of Ownership (CHOW)

1. A completed application for a license to operate a Traumatic Brain Injury Facility, signed and dated.
2. Notarized Affidavit of Personal Identification **and** copy of ID that was shown to the notary public
3. Governing Body Documentation
4. Organizational Chart
5. Copy of the executed legal transaction documents for the business entity (Bill of Sale, closing documents, etc.). This document(s) must be signed by the previous governing body/owner and disclose the effective date of change of ownership/closing.
6. Lease, Warranty Deed, or Bill of Sale for the property

APPLICATION TO OPERATE A
TRAUMATIC BRAIN INJURY FACILITY

SECTION A: IDENTIFICATION

DATE OF APPLICATION: _____
Original _____
Change of Status _____

Name of Facility County

Street Address City/Zip Phone

Official Name of Governing Body

*Name and Address of Principal Officer of Governing Body

*Name of person Delegated Responsibility for Management Title

* Recipients of Official Department Notifications

Levels of Treatment and Rehabilitative Care (Check One or Both)

_____ Transitional Living; _____ Lifelong Living

_____ Bed Capacity

_____ Maximum (C.O.N.); _____ Set up Now

SECTION B: SERVICES PROVIDED
Please place a "1" on the line in front of each service provided by FACILITY STAFF; place a "2" on the line for each service provided UNDER ARRANGEMENT.

__ Occupational Therapy __ Orthotics

__ Psychology __ Pharmaceutical, including monitoring and safe storage

__ Physical Therapy __ Physician

__ Speech-LanguageTherapy __ Prosthetics

__ Audiology
__ Chaplaincy
__ Cognitive Rehab Therapy
__ Dentistry
__ Dietetics/Nutrition
__ Driver Education
__ Family Dentistry
__ Rehabilitation Engineer
__ Respiratory Therapy
__ Social Work
__ Therapeutic Recreation
__ Vocational Rehabilitation
__ Nursing, including administration of medication
__ Neuropsychology

SECTION C: OWERSHIP INFORMATION

Type of Ownership (Check Applicable Category)

Nonprofit	Proprietary	Governmental
__ Church Related	__Individual	__State
__ Nonprofit Assn. or Corp.	__ Partnership	__ County
	__ Corporation	__ City or Municipal
		__ Combination
		__ Hospital Authority

1. List Names and Addresses of all owners with 5% or more interest.

_____
_____
_____
_____
_____

2. List Names and Addresses of Officers of the Corporation.

_____
_____
_____
_____

3. List Names and Addresses of Partners.

_____
_____
_____
_____
_____
_____

SECTION D: CERTIFICATION

I certify that this facility will comply with all rules and regulations for Traumatic Brain Injury Facilities. I further certify that the above information is true and correct to the best of my knowledge.

_____ _____

Signature (Principal Officer of Governing Body) Title

_____

Date

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:

_____

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 subsequent to unlicensed complaint investigation	$550	
Follow-up visit to periodic inspection	$250	License renewal date
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
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
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
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