APPLICATION TO OPERATE A
TRAUMATIC BRAIN INJURY FACILITY

Effective August 3, 2010, a fee must be paid for each new application, change of ownership, change of location, or renewal of license. Before you apply for any new application or changes, please download the payment coupon and submit the correct payment to the mailbox on the coupon form. Then, please follow the directions for the application below.

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
SECTION C: OWNERSHIP INFORMATION

Type of Ownership (Check Applicable Category)

<table>
<thead>
<tr>
<th>Nonprofit</th>
<th>Proprietary</th>
<th>Governmental</th>
</tr>
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<tbody>
<tr>
<td>___ Church Related</td>
<td>___ Individual</td>
<td>___ State</td>
</tr>
<tr>
<td>Nonprofit Assn. or Corp.</td>
<td>___ Partnership</td>
<td>___ County</td>
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<tr>
<td>___ Nonprofit Assn. or Corp.</td>
<td>___ Corporation</td>
<td>___ City or Municipal</td>
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<td></td>
<td>___ Combination</td>
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<td></td>
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<td>___ Hospital Authority</td>
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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 ___________________

(For Department of Community Health Use Only)

Date Received________________ Reviewed By _______________________

Certificate of Need Attached: Yes__ NO__

Permit Number Issued________________ Effective Date _______________________

Approved: ______________________
STATE OF GEORGIA   )
COUNTY OF________  )

AFFIDAVIT RE: PERSONAL IDENTIFICATION
FOR LICENSURE/REGISTRATION

PERSONALLY APPEARED before the undersigned officer, duly authorized to
administer oaths, came the undersigned, who after having been duly sworn, states under
oath, the following:

1. That my name is ___________________________ and that I am who I say I am;

2. That my address is__________________________________________________;

3. That I have presented sufficient personal identification to the notary that is true
and accurate;

4. That I am legally in the United States of America;

5. That I am applying to the Georgia Department of Community Health, Healthcare
Facility Regulation Division, to operate a business activity that is subject to
regulation by the Department of Community Health; and that this affidavit is a
material part of the application; and

6. That if the Department subsequently determines that the material information
 contained in this affidavit is false, I will in violation of licensing/registration
 requirements, which may result in revocation of my license or registration.

Sworn to and subscribed before me )
This _________ day of ______, ___.)
)                     )                      Affiant
)                     )
)____________________________ )
NOTARY PUBLIC
) STATE OF GEORGIA
) My commission expires:__________.
Documents That Establish Identity

For individuals 18 years of age or older:

- Driver’s license or ID card issued by a state or outlying possession of United States provided it contains a photograph or information such as name, date of birth, sex, height, eye color, and address

- ID card issued by federal, state, or local government Agencies or entities provided it contains a photograph or Information such as name, date of birth, sex, height, eye color, and address (including U.S. Citizen ID Card [INS Form I-197] and ID Card for use of Resident Citizen in the U.S. [INS Form I-179])

- School identification card with a photograph

- Voter’s registration card

- United States Military card of draft record

- Military dependent’s identification card

- United States Coast Guard Merchant Mariner Card

- Native American tribal document

- Driver’s license issued by a Canadian government authority