PRIVATE HOME CARE PROVIDER 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 Private Home Care Providers (PHCP) 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 application 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 by our office. The initial review time frame is ***60 business days*** from the application submission date. Failure to submit documents accurately and timely can result in a longer review period.

The official rules for Private Home Care Providers 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 Private Home Care Providers 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 PHCP application web portal and upload required documents is www.mmis.georgia.gov/portal/PubAccess.HFRD/HFRD%20Application/tabId/62/Default.aspx **OR** www.mmis.georgia.gov . Application and licensure fees must be paid in the Georgia Medicaid Management Information System (GAMMIS) Web portal at the time of the application submission. Please retain your license tracking number (LTN) to track the status of your application. 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 the GAMMIS portal. Please continue to monitor your email, including your Junk/Spam folder for emails from the GAMMIS portal. **PLEASE DO NOT MAIL ANY DOCUMENTS TO OUR OFFICE. ALL APPLICATION DOCUMENTS MUST BE UPLOADED IN THE GAMMIS PORTAL.**

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 PHCP rules and regulations, adding counties to an existing permit, removal of services, surveys, plan of corrections, permits, facility letters, Administrator and/or contact information update, i.e., email address, phone numbers, email the PHCP Team at hfrd.phcp@dch.ga.gov.

For general application questions, email the HFRD Applications and Waivers Team at hfrd.applicationswaivers@dch.ga.gov .

Note: Please make sure the information on the application form is correct. Once the application is submitted, changes aren't allowed. Application fees are non-refundable.

All licensure fees must be paid in full prior to receiving a permit or license. For questions regarding licensure fees, contact the HFRD Finance Team at hfrd.payments@dch.ga.gov .

Initial

1. An electronic application completed via GAMMIS Web Portal for a license to operate as a private home care provider.
2. Notarized Affidavit of Personal Identification **and** copy of photo ID
3. Notarized Affidavit of Compliance **(select Private Home Care Providers)**
4. Copy of Business License from local city/county government. The business license must be current with the facility name and address. If you are unable to obtain a business license, provide a written explanation from your local government stating the reason.
5. Copy of Secretary of State, Certificate of Incorporation, if incorporated; or if not incorporated, listing of IRS Tax ID number is acceptable.
6. **Satisfactory determination letter, dated within 12 months of the application submission date**, from the DCH Georgia Criminal History Check System (GCHEXS). All **administrators and individual owners** with 10% or more ownership interest must complete a fingerprint-based background check through GCHEXS. The owner of the facility may request access to GCHEXS by going to GCHEX. For Fingerprint Background Check rules and regulations, visit the Secretary of State website at 111-8-12. For additional information, please visit **DCH OIG**, or by calling at 404-463-7154 or by emailing at gchexs.user@dch.ga.gov .

Note: If there are no individuals that own 10% or more interest, provide a letter on the company letterhead stating this information. The letter must be signed by the owner or owner representative.

7. The Administrator and at least one other employee are required to open a PHCP. A Registered Nurse (RN) is permitted to hold the position as an Administrator, Owner, and Certified Nursing Assistant (CNA).

A RN must be employed as a full time or contracted employee. The required documents for the RN personnel file are:

- Copy of current RN license
- Includes evidence of having a history of no misconduct as described in 111-8-65-.09(5)(a)1. This written statement must be signed and dated by the employee.

8. Name, qualifications, and job description (including copy of professional license, if applicable) for the Administrator (Rule 111-8-65-.09. Administration and Organization).

The required documents for the Administrator personnel file are:

- **Satisfactory determination letter, dated within 12 months of the application submission date**, from the DCH Georgia Criminal History Check System (GCHEXS). For a list of exempted professional healthcare providers, visit **DCH OIG** .
- Job duties include full authority and responsibility for the operation of the PHCP as described in 111-8-65- .09(3). The job duties must be signed and dated by the employee.
- Evidence of having a history of no misconduct as described in 111-8-65-.09(3)(a)1. This written statement must be signed and dated by the employee.
- Evidence of completion of orientation training as described in 111-8-65-.09(6)(a). The orientation training must include items #1 through #4, signed and dated by the Administrator.

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

Change of Ownership (CHOW)

1. An electronic application completed via GAMMIS Web Portal for a license to operate as a private home care provider. ***New Owner information must be listed on the application form. ***

2. Copy of Secretary of State, Certificate of Incorporation, if incorporated; or if not incorporated, listing of IRS Tax ID number is acceptable.
3. 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.

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.

4. Copy of Business license from your local city or county government. The business license must be current with the facility name and address. If you are unable to obtain a business license, provide a written explanation from your local government stating the reason.
5. Notarized Affidavit of Personal Identification **and** copy of photo ID
6. Notarized Affidavit of Compliance **(select Private Home Care Providers)**
7. **Satisfactory determination letter, dated within 12 months of the application submission date**, from the DCH Georgia Criminal History Check System (GCHEXS). All administrators and individual owners with 10% or more ownership interest must complete a fingerprint-based background check through GCHEXS. The owner of the facility may request access to GCHEXS by going to GCHEX. For Fingerprint Background Check rules and regulations, visit the Secretary of State website at 111-8-12. For additional information, please visit **DCH OIG**, or by calling at 404-463-7154 or by emailing at gchexs.user@dch.ga.gov .

Note: If there are no individuals that own 10% or more interest, provide a letter on the company letterhead stating this information. The letter must be signed by the owner or owner representative.

Governing Body Name Change

1. An electronic application completed via GAMMIS Web Portal for a license to operate as a private home care provider. ***New governing body name must be listed on the application form***
2. Copy of Secretary of State, Certificate of Incorporation, if incorporated; or if not incorporated, listing of IRS Tax ID number is acceptable.
3. Notarized Affidavit of Personal Identification **and** copy of photo ID
4. Notarized Affidavit of Compliance **(select Private Home Care Providers)**

Facility Name Change

1. An electronic application completed via GAMMIS Web Portal for a license to operate as a private home care provider. ***New facility name must be listed on the application form***
2. If name of the business and governing body is the same, upload a copy of the Secretary of State, Certificate of Incorporation or Certificate of Organization.
3. Notarized Affidavit of Personal Identification **and** copy of photo ID

Change of Administrator

1. An electronic application completed via GAMMIS Web Portal for a license to operate as a private home care provider.

No fee is required

Change of Location

1. An electronic application completed via GAMMIS Web Portal for a license to operate as a private home care provider. ***New address must be listed on the application form***
2. Copy of Business license from your local city or county government. The business license must be current with the facility name and address. If you are unable to obtain a business license, provide a written explanation from your local government stating the reason.
3. Notarized Affidavit of Personal Identification **and** copy of photo ID

Change of Services (Additions)

1. An electronic application completed via GAMMIS Web Portal for a license to operate as a private home care provider.
2. Notarized Affidavit of Personal Identification **and** copy of photo ID
3. Notarized Affidavit of Compliance **(select Private Home Care Providers)**

How to Apply

To submit a new PHCP application, click on www.mmis.georgia.gov/portal/PubAccess.HFRD/HFRD%20Application/tabId/62/Default.aspx **OR** www.mmis.georgia.gov, click on HFRD, select HFRD Application, then follow the steps.

How to check the status of an existing application

For application status updates, click on www.mmis.georgia.gov/portal/PubAccess.HFRD/HFRD%20Application/tabId/62/Default.aspx **OR** www.mmis.georgia.gov, click on HFRD, select HFRD Application Status, then follow the steps.

How to complete a PHCP Application

www.mmis.georgia.gov/portal/PubAccess.HFRD/HFRD%20Application/tabId/62/Default.aspx **OR** www.mmis.georgia.gov, click on HFRD, scroll to the bottom of the page, click on How to complete an HFRD Web Application, then follow the steps.

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Brian P. Kemp, Governor **Russel Carlson, Commissioner**

2 Martin Luther King Jr. Dr. SE 17th fl. | Atlanta, GA 30334 | 404-657-5700 | 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 Name

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 Name

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:

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:

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