HOSPICE APPLICATION CHECKLIST
(Application changes for providers with current permits)

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 Hospice 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 Hospice 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 Hospice 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 the Hospice Team. Please continue to monitor your email, including your Junk/Spam folder for emails from workflow@dch.ga.gov . ***DO NOT REPLY TO workflow@dch.ga.gov .*** This is an automated response, and replies will not be read.

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 Hospice Rules and Regulations, surveys, permits, and changes for providers with current permits, email the Hospice Team at hfrd.hospicehh@dch.ga.gov .

Note: Application fees are non-refundable. All licensure fees must be paid in full prior to receiving a permit or license.

Addition of Services

1. A completed licensure application
2. $300 application fee
3. Provide a letter on business letterhead requesting the type of service(s)
4. Provide an update of your policies that reflect the addition of services (Please refer to the regulations).

Branch Addition

1. A completed licensure application
2. $300 application fee
3. Provide a letter on business letterhead indicating the parent agency the branch will be billing under and the counties the branch will be servicing.

4. Notarized Affidavit for Hospice Nursing Services and County Approval
5. If the branch serves counties currently not authorized under the parent agency, you will need to request an addition of counties on the application.

Name Change (Doing Business as Only)

1. A completed licensure application
2. $300 application fee
3. Provide a letter on business letterhead explaining the change and the effective date.

Governing Body Name Change (Not a Change of Ownership)

1. A completed licensure application
2. $300 application fee
3. Provide a letter on business letterhead explaining the change and the effective date.
4. Georgia Secretary of State Certificate, if applicable

Relocation

1. A completed licensure application
2. $300 application fee
3. Notarized Affidavit for Hospice Nursing Services and County Approval
4. If new location, provide a letter on business letterhead explaining if this will impact current patients being served. If so, provide a plan that shows how the agency will accommodate the patient(s).

Service Area Changes (add/remove counties)

1. A completed licensure application
2. $300 application fee
3. Provide a letter on business letterhead indicating counties that are currently being served, and counties that need to be added or removed.
4. If the updated county will impact current patients being served, provide a plan that shows how the agency will accommodate the patient(s).
5. Notarized Affidavit for Hospice Nursing Services and County Approval

In-patient Unit (IPU) Bed Changes

1. A completed Application for a license to operate a Hospice, signed and dated.
2. $300 application fee
3. Provide a letter on business letterhead indicating which parent agency the IPU operates under.
4. Floor plan showing expansion for bed increase
5. Certificate of Occupancy from State Fire Marshal's office

Georgia Department Of Community Health
Healthcare Facility Regulation Division
Health Care Section
2 Martin Luther King Jr. Dr. SE, East Tower 17th Floor
Atlanta, Georgia 30334

APPLICATION FOR A LICENCE TO OPERATE A HOSPICE

(PLEASE TYPE OR PRINT)

Pursuant to provision of O.C.G.A § 31-7-170 et seq. application is hereby made to operate a Hospice which is identified as follows:

SECTION A: IDENTIFICATION

Date of Application:

Type of Application	☐ Initial ☐ Change of Ownership (CHOW) ☐ Change of Services	☐ Name Change ☐ Address Change ☐ Bed Capacity Change	Other

Name of Hospice | County

Street Address | City and Zip Code

E-mail Address | Telephone: _____
FAX: _____

Mailing Address (If different from Street Address)

Name of Administrator | Official Title

Official Name and Address of Governing Body

Counties Served By Hospice

Section B: TYPE OF OWNERSHIP (Check Only One)

PROPRIETARY (Profit):		NON-PROFIT:	
☐ Individual	☐ Partnership	☐ State	☐ Hospital Authority
☐ Corporation	☐ LLC	☐ County	☐ Church
☐ Other(Specify)_____		☐ City	☐ Other(Specify)_____

Agent for Service – Name | Address and Telephone Number

Proof of Ownership Attached:

☐ Certificate of Incorporation (Copy)
☐ Other:_____

SECTION C: SERVICES PROVIDED

☐ Home Care Only	☐ Free Standing Acute Inpatient Services # of Beds_____ Address: _____ _____ _____	☐ Acute & Residential Combined Services # of Beds_____ Address: _____ _____ _____	☐ Free Standing Residential Services # of Beds_____ Address: _____ _____ _____

SECTION D: STATEMENT OF COMPLIANCE

I certify that this hospice will comply with the Rules and Regulations for Hospices, Chapter 290-9-43, pursuant to the Official Code of Georgia Annotated (O.C.G.A.) 31-7-170 *et seq.* I further certify that the information submitted on this application is true and correct to the best of my knowledge.

_____ _____ _____

Signature of Administrator or Executive Officer of the Governing Body | Title | Date

TO BE FILLED OUT BY STATE AGENCY ONLY

DATE RECEIVED _____

LICENSE NUMBER ISSUED _____ **APPROVED** _____

HOME CARE SERVICE PROGRAM DIRECTOR

EFFECTIVE DATE _____

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Georgia Department of Community Health Healthcare Facility Regulation Division

Affidavit for Hospice Nursing Services and County Approval

Name of Parent Facility (Licensee)	
Name of Affiant (Authorized Representative of Parent Facility governing body):	
Parent Facility Address:	

COUNTY OF: _____

STATE OF: _____

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

A. I, the above-named Affiant, have personal knowledge of the matters addressed in this affidavit the attestations made herein.

B. 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.

C. I swear or affirm that I am a duly authorized representative of the governing body of above-named Parent Facility located at the above listed address which is currently licensed through the Healthcare Facility Regulation Division, as a Hospice, as pursuant to and defined in O.C.G.A. §§ 31-7-170*et seq.* Short Title known as the Georgia Hospice Law, and Ga. Comp. R. & Regs.111-8-37 Rule and Regulations for Hospices (hereinafter known to as the governing body of law and regulations.)

D. I swear or affirm that the Licensee has _____ (total number of facilities) located at:

1. _____
2. _____
3. _____

Use additional sheets if necessary.

E. Pursuant to the aforementioned body of laws, the Affiant requests to provide hospice services to the following county(s):

1.	2.	3.
4.	5.	6.
7.	8.	9.

Use additional sheets if necessary.

F. I understand that on-site nursing services must be available within one hour of notification where terminally ill patients or the patient with an advanced and progressive disease who has contracted for nursing services experiences a symptom management crisis situation.

G. I understand the Hospice must be able to present, when requested, documentation including date and time received of each notification or request where a terminally ill patient or patient with an advanced progressive disease request nursing services and document the nurse's on-site arrival time.

H. I understand the Hospice must maintain an on-call log for all calls received after normal business hours, the log record must contain, but not be limited to, the of name of caller, date and time of the call, arrival time of the nurse to the residence, and the purpose of the call. These records must be kept for a minimum of two (2) years as defined by the governing body of laws.

I. I understand that Licensee must remain in substantial compliance with the Healthcare Facility Regulation Division, Rules, and Regulations for the Hospice to maintain licensed access to the requested counties, and that such license may be disciplined by citations, fines, and up to revocation by Healthcare Facility Regulation Division for Licensee's failure to substantially comply with the Rules.

J. I hereby submit this Affidavit for the Healthcare Facility Regulation Division's consideration to grant licensed access for the counties referenced above to the above-named Licensee.

K. I understand and acknowledge that the Healthcare Facility Regulation Division will rely upon the sworn statements made herein in making a determination regarding the licensed access to service the counties requested.

_____ _____

Signature of Affiant **Date of Signature**

_____

Printed Name of Affiant

SUBSCRIBED AND SWORN BEFORE ME ON

THIS THE_____DAY OF_____20_____

Notary Public

My Commission Expires: _____