HOME HEALTH AGENCY 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 Home Health Agency (HHA) 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 Home Health Agencies 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 Home Health Agencies 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 browser, and upload the requested documents.*** 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 HHA Rules and Regulations, surveys, plan of corrections, permits, facility letters, Administrator and/or contact information update, i.e., email address, phone numbers, email the Home Health Team at hfrd.hospicehh@dch.ga.gov .

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

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

Initial/New Permit

1. A completed Application for a license to operate a Home Health Agency, signed and dated.
Note: 10 County limit on initials
2. Notarized Affidavit of Personal Identification **and** copy of photo ID
3. Notarized Affidavit of Compliance **(select Home Health Agencies)**
4. **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 company letterhead stating this information. The letter must be signed by the owner or owner representative.

5. 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.

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

7. Certificate of Need approval from GA Department of Community Health, Office of Health Planning (OHP) and 1122 Review. For more information, visit DCH OHP website at https://dch.georgia.gov/con-applications-and-forms .

8. Copy of organizational chart and policies and procedures regarding administrative control, lines of authority, and scope of services provided. **Rule 111-8--31- .07(1)**

9. Policies that define the scope of services provided by the agency. **Rule 111-8--31- .07(1)**

10. Policy regarding the role of the Governing Body/Board of Directors. Name and address for each board member and owner(s). **Rule 111-8-31-.07(2)**

11. Home Health budget plan for 1st year.

12. Description of composition and responsibilities of a group of professional personnel (i.e., policy or procedure). Must contain all required members including but not limited to MD, Admin, DON, HHA, Medical SW and RN. **Rule 111-8-31-.07 (3)(a)**

Note: Responsibilities include establish an annually review of policies, quarterly meetings with documentation of meeting minutes, participation in evaluation of agency's program, and assist in maintaining liaison with community.

13. Name, qualifications, and signed job description, (including professional license, if applicable) of administrator. Meets qualification requirements of either: Licensed physician; or Licensed registered nurse; or has training and experience in health service administration and at least one (1) year of supervisory or administrative experience in home health care or related health programs.

Job duties/responsibilities include:

- Ensures responsibility and accountability for organizing and directing the agency's ongoing functions.
- Maintains ongoing liaison among the Governing Body, group of professional personnel, and the staff.
- Ensures employment of qualified staff.
- Ensures adequate staff education and evaluations.
- Ensures the accuracy of public information, materials, and activities.
- Ensures the implementation of an effective budgeting and accounting system.

14. Policy regarding delegation of authority in the absence of the administrator. **Rule 111-8-31-.07(5)**

15. Policies regarding personnel practices, including contract personnel. **Rule 111-8-31-.07(6)**

Names, qualifications, and signed job descriptions, for all staff members and contract personnel, including current licenses where applicable and health examinations.

16. Copies of any contracts for hourly or per-visit personnel.

17. Name, qualifications, signed job description, and evidence of current license for the supervisor/director of nursing services.
18. Licensure fee (see Schedule of Licensure Activity Fees).

Change of Ownership (CHOW)

1. A completed Application for a license to operate a Home Health Agency, signed and dated.
2. Copy of Secretary of State, Certificate of Incorporation & Articles of Incorporation
3. Copy of tax identification number
4. 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.

5. Organizational charts of the governing body pre- and post-sale transaction
6. 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.
7. Notarized Affidavit of Personal Identification **and** copy of photo ID
8. **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 company letterhead stating this information. The letter must be signed by the owner or owner representative.

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
Healthcare Facility Regulation Division
2 Martin Luther King Jr. Dr. SE, East Tower 17th Floor
Atlanta, Georgia 30334

APPLICATION FOR A LICENSE TO OPERATE A HOME HEALTH AGENCY

Pursuant to provision of O.C.G.A. §31-7-150 et.seq. application is hereby made to operate a Home Health Agency which is identified as follows:

Section A: IDENTIFICATION

Date of Application: _____

Type of Application: ☐ INITIAL ☐ RENEWAL ☐ CHOW

NAME OF AGENCY		COUNTY OF PARENT AGENCY
STREET ADDRESS	CITY AND ZIP CODE	TELEPHONE
NAME OF ADMINISTRATOR / DIRECTOR		TITLE
OFFICIAL NAME AND ADDRESS OF GOVERNING BODY		
NUMBER OF BRANCH OFFICES	COUNTIES SERVED (BY ENTIRE AGENCY)	

Section B: TYPE OF OWNERSHIP (Check one)

Proprietary (Profit)	**Nonprofit**	
☐ Individual	☐ State	☐ Hospital Authority
☐ Partnership	☐ County	☐ Church
☐ Corporation	☐ City	☐ Other(Specify)

Agent for Service / Name:	Address and Telephone Number:

1. List names and addresses of all owners with 5% or more interest:

_____

_____

_____

_____

_____

2. Agencies Organized as a Corporation or Partnership – List names and addresses of officers of the corporation or principle partners:

_____

_____

_____

_____

Section C: HOME HEALTH SERVICES PROVIDED

"1" Provided by Agency
"2" Under Arrangement
"3" Combination

		STAFFING (List Full-Time Equivalent)		
		Registered Nurse		
☐	Nursing Care	Licensed Practical Nurse		
☐	Physical Therapy	Physical Therapist		
☐	Occupational Therapy	Occupational Therapist		
☐	Speech Therapy	Speech Pathologist/Audiologist		
☐	Medical Social Worker	Social Worker		
☐	Home Health Aide	Home Health Aide		
☐	Nutritional Guidance	Dietitian		
☐	Pharmaceutical Services	Pharmacist		
☐	Other (Administrative Secretary, etc.)	All Other		

Section D: CERTIFICATION

I certify that this agency will comply with the Rules and Regulations for Home Health Agencies (Chapter 290-5-38). I further certify that the above information is true and correct to the best of my knowledge.

Signature: _____ Title: _____
Administrator or Officer authorized to complete application

(TO BE COMPLETED BY DCH PERSONNEL ONLY)

Copy of Corporate Charter attached? (if applicable) ☐ YES ☐ NO

Permit Number: _____

Effective Date: _____

Copy of Certificate of Need attached? (if applicable) ☐ YES ☐ NO ☐ N/A

Licensure fee received: ☐ YES ☐ NO

Reviewed by: _____

Approved: _____
Regional Director

Section E: HOME HEALTH AGENCY AND BRANCH OFFICE ADMISSION DATA

Date: _____

Does you parent office directly provide clinical services? ☐ YES ☐ NO

If not, please list the address where clinical services are provided in the agency (PARENT) column below:

PLEASE PROVIDE ADMISSION DATA FOR THE PARENT AND BRANCH OFFICES FOR THE PAST 12 MONTHS	TOTAL NUMBER MEDICARE – MEDICAID ADMISSIONS (All first time admissions) IN THE PAST 12 MONTHS	TOTAL NUMBER SKILLED (All payment Sources) ADMISSIONS IN THE PAST 12 MONTHS	PLEASE CHECK EACH CATEGORY OF PAYOR SOURCE DELIVERED IN EACH SEPARATE OFFICE OR BRANCH	PLEASE PROVIDE BELOW NARRATIVE DIRECTIONS OF HOW TO REACH EACH OFFICE FROM ATLANTA
NAME OF AGENCY (Parent) Address: _____ City / Zip: _____ Phone: _____ Counties Served: _____			Medicare: _____ Medicaid: _____ CCSP: _____ Insurance: _____ Private Pay _____	
1. BRANCH OFFICE Address: _____ City / Zip: _____ Phone: _____ Counties Served: _____			Medicare: _____ Medicaid: _____ CCSP: _____ Insurance: _____ Private Pay _____	
2. BRANCH OFFICE Address: _____ City / Zip: _____ Phone: _____ Counties Served: _____			Medicare: _____ Medicaid: _____ CCSP: _____ Insurance: _____ Private Pay _____	
3. BRANCH OFFICE Address: _____ City / Zip: _____ Phone: _____ Counties Served: _____			Medicare: _____ Medicaid: _____ CCSP: _____ Insurance: _____ Private Pay _____	

(Attach extra sheets if necessary)

* ATTACH DETAILED DIRECTIONS FROM ATLANTA TO AGENCY

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:

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

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

2 Martin Luther King Jr. Dr. SE, East Tower, 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:

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