HOME HEALTH AGENCY 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 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 the Home Health 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 HHA Rules and Regulations, surveys, permits, and changes for providers with current permits, email the Home Health 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.

Branch Addition

1. Approval from DCH, Office of Health Planning
2. A completed licensure application
3. $300 application fee
4. Provide a letter on business letterhead indicating the parent agency the branch will be billing under and the counties the branch will be servicing.
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.

6. Google map showing distance from main agency to each county being serviced (i.e., 2 Martin Luther King Jr. Dr. SE, East Tower, 17th Fl. Atlanta, GA 30334 to Fulton County, GA).

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. Approval from DCH, Office of Health Planning
2. A completed licensure application
3. $300 application fee
4. If new location, provide a letter on business letterhead explaining if this will impact the current patients being served. If so, provide a plan that shows how the agency will accommodate the patient(s).
5. Google map showing distance from main agency to each county being serviced (i.e., 2 Martin Luther King Jr. Dr. SE, East Tower, 17th Fl. Atlanta, GA 30334 to Fulton County, GA).

Service Area Changes (Add/Remove counties)

1. Approval from DCH, Office of Health Planning
2. A completed licensure application
3. $300 application fee
4. Cover letter on the company's letterhead indicating the counties they currently serve, and the counties they want to add or remove.
5. Provide a letter on business letterhead explaining if this change will impact current patients being served. If so, provide a plan that shows how the agency will accommodate the patient(s).
6. Google map showing distance from main agency to each county being serviced (i.e., 2 Martin Luther King Jr. Dr. SE, East Tower, 17th Fl. Atlanta, GA 30334 to Fulton County, GA).

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