

END STAGE RENAL DISEASE FACILITY 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 End Stage Renal Disease (ESRD) Facility 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 End Stage Renal Disease Facilities 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 End Stage Renal Disease Facilities 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 ESRD Rules and Regulations, surveys, plan of corrections, permits, facility letters, Administrator and/or contact information update, i.e., email address, phone numbers, email hfrd.specialized@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

1. A completed Application for a license to operate an End Stage Renal Disease Facility, signed and dated.
2. Notarized Affidavit of Personal Identification **and** copy of photo ID
3. CMS 3427
4. Attestation Form for Medicare Certification Purpose

5. CMS 855 approval letter (required by the program after an initial licensure survey)
6. Licensure fee Licensure fee (see Schedule of Licensure Activity Fees).

Change of Ownership (CHOW)

1. A completed Application for a license to operate an End Stage Renal Disease Facility, signed and dated.
2. Notarized Affidavit of Personal Identification **and** copy of photo ID
3. CMS 3427
4. Attestation Form for Medicare Certification Purpose
5. 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.

6. CMS 855 approval letter (required upon application submission)

Relocation

1. A completed Application for a license to operate an End Stage Renal Disease Facility, signed and dated.
2. Letter from facility requesting change, provide the old and new addresses and the expected relocation date
3. CMS 855 approval letter (required upon application submission)

Name Change

1. A completed Application for a license to operate an End Stage Renal Disease Facility, signed and dated.
2. Letter from facility requesting the change
3. CMS 855 approval letter (required upon application submission)

Addition/Deletion of Stations

1. A completed Application for a license to operate an End Stage Renal Disease Facility, signed and dated.
2. Letter from facility requesting change
3. CMS 3427

Change in Services

1. A completed Application for a license to operate an End Stage Renal Disease Facility, signed and dated.
2. Letter explaining the requested change(s)
3. CMS 3427

**GEORGIA DEPARTMENT OF COMMUNITY HEALTH
 HFRD, SPECIALIZED CARE UNIT
 2 Martin Luther King Jr. Dr. SE, East Tower 17th Floor
 ATLANTA, GA 30334**

APPLICATION FOR LICENSE TO OPERATE AN ESRD FACILITY

Pursuant to the provisions of O.C.G.A. 111-8-22 et seq. Application is hereby made to operate an ESRD facility which is identified as follows:

Section A: Identification

Date of Application _____

Type of Application: Initial _____ Change of Ownership _____ Address Change _____

Name Change _____ Station Change _____ Administrator Change _____ Addition of Services _____

Other (Specify) _____

Name of Facility		
Street Address	City, State, and Zip Code	
County	Mailing Address (If Different)	
Phone #	Fax #	E-mail Address
Official Name & Address of Governing Body		
Owner of Facility	Name of Administrator	Title
Agent for Service	Address	Phone #

Section B: Ownership Information-Type of Ownership (Check Only One)

Proprietary (Profit)	Non Profit	
____ Individual	____ State	____ Church
____ Partnership	____ County	____ Other (Specify)
____ Corporation (Include copy of certificate of incorporation)	____ City	_____
____ Other (Specify) _____	____ Hospital Based	

List names & address of all owners with five percent or more interest (attach additional sheets if needed):

If facility is organized as a corporation list names & addresses of officers of the corporation (Attach additional sheets if necessary):

Section C: Facility Data

- Date of initial service_____
- Number of Hemodialysis Stations_____
- Total Number of requested Stations_____
- Peritoneal Dialysis services offered: yes_____no_____
- Does the facility have documentation to support that all of its patient care technicians have satisfactorily completed a nationally standardized competency test: yes_____no_____
- Provide reason for expansions and submit a floor plan

Section D: Certification

I certify that the ESRD facility will comply with all rules and regulations, Chapter 111-8-22. I further certify that the above information is true to the best of my knowledge.

Signature of Principal Officer of Governing Body

Title

Print Name of Principal Officer of Governing Body

Date

FOR STATE USE ONLY

Date Received_____ **Reviewed by**_____

Permit Number_____ **Effective Date**_____

Approved by_____

Regional Director

**Georgia Department of Community Health
Healthcare Facility Regulation Division
2 Martin Luther King Jr. Dr. SE, East Tower 17th Floor
Atlanta, Georgia 30334
404-657-5850
www.dch.georgia.gov**

Instructions: Complete form and submit with application to Healthcare Facility Regulation Division if facility qualifies for exemption as outlined below.

**ATTESTATION STATEMENT FOR MEDICARE CERTIFICATION PURPOSE
Life Safety Code Attestation for Exempt End Stage Renal Disease (ESRD) Facilities**

Facility Name: _____ CCN: _____

Facility Address: _____

I attest to the following:

The above named facility provides one or more exits to the outside at grade level from the patient treatment level. *(Note that the patients' exit path from the treatment area may include an accessibility ramp that complies with the Americans with Disabilities Act (ADA));*

AND

The above named facility is not adjacent to high hazardous occupancy. *(Note: This type of occupancy is defined in The National Fire Protection Association (NFPA) Life Safety Code 101, 2000 Edition at § A.3.3.134.8.2 as "occupancies where gasoline and other flammable liquids are handled, used, or stored under such conditions that involve possible release of flammable vapors; where grain dust, wood, or plastic dusts, aluminum or explosives are manufactured, stored, or handled; where cotton or other combustible fibers are processed or handled under conditions that might produce flammable flying; and where other situations of similar hazard exist.")*

The facility agrees to notify the Centers for Medicare & Medicaid Services (CMS) if there are any structural changes that would cause the facility to no longer meet the exemption requirements.

Signature of Facility Administrator:

Date:

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:

- 1) _____ I am a United States citizen.
- 2) _____ I am a legal permanent resident of the United States.
- 3) _____ 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 this the ____ day of _____, 20 ____ 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: <ul style="list-style-type: none"> • New Application • Change of Ownership • Change in Service Level (Requiring on site visit) • Name Change 	\$300	Upon submission
Initial License Fee (Same as 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		
<p>*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.</p>		
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