HOSPICE 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 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 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 Hospice Rules and Regulations, surveys, plan of corrections, permits, facility letters, Administrator and/or contact information update, i.e., email address, phone numbers, email the Hospice 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

1. A completed Application for a license to operate a Hospice, 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 Hospice**)
4. Notarized Affidavit for Hospice Nursing Services and County Approval
5. **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.

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. Copy of Secretary of State, Certificate of Incorporation, if incorporated; or if not incorporated, listing of IRS Tax ID number is acceptable.
8. Hospice budget plan for 1st year.
9. Description of services as defined by the Governing Body. **Rule 111-8--37-.07 (1)-(6)**
10. Designation of the individual responsible to act for the administrator during any period the administrator is absent and the individual responsible for the Quality Management program. **Rule111-8-37-07 (5)(f)**
11. Staff list, indicating whether employed, contracted, or volunteer.
12. Name, qualifications, and signed job description (including copy of professional license if applicable) of administrator. Meets qualification requirements of either (check): Licensed healthcare professional with one year supervisory or management exp. in a hospice setting; or Education, training, and experience in health service administration with two years supervisory or management Experience in a hospice setting.

Job duties requirements must include:
-Ensures that policies are developed w/ the IDT team
-Ensure employment of qualified staff
-Ensures policies and procedures are implemented
-Ensures a qualified DON and sufficient staff
-Ensures there is an orientation, training, & supervision for every employee and that they complete these programs
-Ensures that there are effective communication mechanisms for staff, patients, and families.

13. Names, qualifications, and signed job descriptions for all staff members, including verification of licensure where applicable.
14. Copy of orientation curriculum. Hospice concepts and philosophy Patient Rights Hospice policies and procedures includes Reporting of abuse and neglect, disaster preparedness, and fire safety and emergency evacuations. **Rule 111-8-37-.13(2)**
15. Evidence of an initial health screening for each employee and volunteer completed by a MD, DO, NP, or PA, TB screening and Hepatitis vaccinations or signed documentation of refusal/declination. **Rule 111-8-37-.13(5)**
16. Copies of any contracts for professional services from independent contractors.
17. Copy of procedure for reporting abuse or neglect requirement for employees/volunteers **and**

confirmation that all employees/volunteers have completed abuse or neglect training. **Rule 111-8-37-.13(4)**
18. A signed statement from a licensed pharmacist (GA License) that policies and procedures for management of drugs and biologicals have been reviewed and approved. Provide a copy of the pharmacist's license. **Rule 111-8-37-.21 (2)(a)**
19. Licensure fee (see Schedule of Licensure Activity Fees).

Change of Ownership (CHOW)

1. A completed Application for a license to operate a Hospice, 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.

New Hospice Inpatient Unit (IPU) or Residential Unit

1. A completed Application for a license to operate a Hospice, signed and dated.
2. Submit the floor plan for review by this office
3. An attestation statement indicating that the IPU site will be owned and operated by the same governing body and that one medical director will assume responsibility for the medical component at this location
4. Attach organizational chart delineating lines of authority, professional and administrative control for the hospice and the additional site
5. Notarized Affidavit of Personal Identification **and** copy of photo ID

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 ___________________________

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:

____

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:

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.

Georgia Department of Community Health

Georgia Department of Community Health Healthcare Facility Regulation Division

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: __________________________

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