NURSING HOME 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 Nursing Home (NH) 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 Nursing Homes 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 Nursing Homes 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 NH Rules and Regulations, surveys, plan of corrections, permits, facility letters, Administrator and/or contact information update, i.e., email address, phone numbers, email hfrd.nh@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 Nursing Home, signed and dated by the Owner. If a corporation - include Certificate of Incorporation and Articles of Incorporation for **ALL** corporations having an interest in the nursing home (the licensee corporation must be registered in Georgia)

If partnership - include Partnership Agreement
If Limited Liability Company (LLC) - include Certificate of Organization and Articles of Organization for **ALL** LLCs with an interest in the nursing home (the licensee company must be registered in Georgia)
If a non-profit - include documentation of non-profit status [501(c) 3]

2. Notarized Affidavit of Personal Identification **and** copy of photo ID
3. Certificate of Need that indicates the number of beds approved by the DCH, Office of Health Planning. For more information, visit DCH OHP website at: https://dch.georgia.gov/divisionsoffices/office-health-planning .
4. A copy of proof of ownership/legal control of the property (deed, lease, or bill of sale)
5. Disclosure of Ownership & Control Form
6. Georgia State Fire Safety approval for the requested bed count
7. Nursing Home/Hospital Patient Transfer Agreement
8. Proof of liability insurance or a self-insurance trust
9. **New buildings**: submit a copy of the floor plan with the bed breakdown.

Existing buildings: include the floor plan only if changes have been made to the previous floor plan.

Will the facility participate in the Federal Medicare and Medicaid Program? Yes _____No _____
If yes, provide Items #10 through #12, if not, skip to Item #13:

10. CMS 671 - LTC Facility Application for Medicare/Medicaid (See the CMS website)
11. CMS 1561 - Health Insurance Benefits Agreement
12. Copy of the Assurance of Compliance HHS 690 electronic confirmation letter

**The Dept. of Health and Human Services Assurance of Compliance (HHS 690) use the online web portal at: https://ocrportal.hhs.gov/ocr/aoc/aocContact.jsf **

13. Licensure fee (see Schedule of Licensure Activity Fees).

Change of Ownership (CHOW)

1. A completed application for a license to operate a Nursing Home, signed and dated by the New Owner.

If a corporation - include Certificate of Incorporation and Articles of Incorporation for **ALL** corporations having an interest in the nursing home (the licensee corporation must be registered in Georgia)
If partnership - include Partnership Agreement
If Limited Liability Company (LLC) - include Certificate of Organization and Articles of Organization for **ALL** LLCs with an interest in the nursing home (the licensee company must be registered in Georgia)
If a non-profit - include documentation of non-profit status [501(c) 3]

2. Notarized Affidavit of Personal Identification **and** copy of photo ID
3. A copy of proof of ownership/legal control of the property (deed, lease, or bill of sale)
4. Copy of the executed legal transaction documents for the business entity (Bill of Sale, closing documents, etc.). The 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. Disclosure of Ownership & Control Form

6. Nursing Home/Hospital Patient Transfer Agreement
7. Proof of liability insurance or a self-insurance trust for the new owner

8. **Capacity Increase?** Yes _____ No _____

If yes, then please provide the following additional documentation:

a) Certificate of Need that indicates the number of beds approved by the DCH Office of Health Planning. For more information, visit DCH OHP website at: https://dch.georgia.gov/divisionsoffices/office-health-planning .
b) Georgia State Fire Safety approval for the requested bed count
c) Floor Plan that indicates where the additional beds are located and the location of any building construction or renovation.

Will the facility participate in the Federal Medicare and Medicaid Program? Yes _____No _____

If yes, provide Items #9 through #11:

9. CMS 671 - LTC Facility Application for Medicare/Medicaid (See the CMS website)
10. CMS 1561 – Health Insurance Benefits Agreement
11. Copy of the Assurance of Compliance HHS 690 electronic confirmation letter

**The Dept. of Health and Human Services Assurance of Compliance (HHS 690) use the online web portal at: https://ocrportal.hhs.gov/ocr/aoc/aocContact.jsf **

Relocation/Replacement Facility

1. A completed application for a license to operate a Nursing Home, signed and dated by the Owner.

If a corporation - include Certificate of Incorporation and Articles of Incorporation for **ALL** corporations having an interest in the nursing home (the licensee corporation must be registered in Georgia)

If partnership - include Partnership Agreement

If Limited Liability Company (LLC) - include Certificate of Organization and Articles of Organization for **ALL** LLCs with an interest in the nursing home (the licensee company must be registered in Georgia)

If a non-profit - include documentation of non-profit status [501(c) 3]

2. Notarized Affidavit of Personal Identification **and** copy of photo ID
3. A copy of proof of ownership/legal control of the property (deed, lease, or bill of sale)
4. Certificate of Need that indicates approval of the new location and the bed count from the DCH Office of Health Planning. For more information, visit DCH OHP website at: https://dch.georgia.gov/divisionsoffices/office-health-planning .
5. Georgia State Fire Safety approval for the requested bed count
6. Proof of liability insurance or a self-insurance trust for the new owner
7. Provide a copy of the facility floor plan

Facility Name Change

1. A completed application for a license to operate a Nursing Home, signed and dated by the Owner with the new facility name.
2. Notarized Affidavit of Personal Identification **and** copy of photo ID

Governing Body Name Change/Licensee name (not a CHOW)

1. A completed application for a license to operate a Nursing Home, signed and dated by the Owner with the new governing body/licensee name.
2. Notarized Affidavit of Personal Identification **and** copy of photo ID

Capacity Increase

1. A completed application for a license to operate a Nursing Home, signed and dated by the Owner.
If a corporation - include Certificate of Incorporation and Articles of Incorporation for **ALL** corporations having an interest in the nursing home (the licensee corporation must be registered in Georgia)
If partnership - include Partnership Agreement
If Limited Liability Company (LLC) - include Certificate of Organization and Articles of Organization for **ALL** LLCs with an interest in the nursing home (the licensee company must be registered in Georgia)
If a non-profit - include documentation of non-profit status [501(c) 3]
2. Notarized Affidavit of Personal Identification **and** copy of photo ID
3. Certificate of Need that indicates the number of beds approved by the DCH Office of Health Planning. For more information, visit DCH OHP at: https://dch.georgia.gov/divisionsoffices/office-health-planning .
4. Georgia State Fire Safety approval for the requested bed count
5. Provide a copy of the facility floor plan that indicates where the additional beds are located and the location of any building construction or renovation.

Capacity Decrease

1. A completed application for a license to operate a Nursing Home, signed and dated by the Owner.
2. Notarized Affidavit of Personal Identification **and** copy of photo ID

GEORGIA DEPARTMENT OF COMMUNITY HEALTH HEALTH CARE FACILITY REGULATION DIVISION
2 Martin Luther King Jr. Dr. SE, East Tower 17th Floor
Atlanta, Georgia 30334

APPLICATION FOR A PERMIT TO OPERATE A NURSING HOME OR AN INTERMEDIATE CARE HOME

Pursuant to provisions of Chapters 290-5-8 and 290-5-9, Rules and Regulations for Nursing Homes or Intermediate Care Homes, as applicable, and Regulations for General Licensing and Enforcement Requirements Chapter 111-8-25, application is hereby made to operate a facility which is identified as follows:

SECTION A: FACILITY IDENTIFICATION

Type of Application: ☐ Original ☐ Name Change
☐ Change Ownership (Governing Body) ☐ Other

Name of Facility _____ County _____

Street Address _____ Email Address _____

City and Zip _____ Phone _____ Fax _____

Governing Body (Give Name of Owner, Partnership, Corporation, Association, Authority)		
Administrator's Name	License Number	Director of Nurses

SECTION B: OWNERSHIP IDENTIFICATION

1. Type of Ownership (check only one)

Non-profit	**Proprietary**	**Governmental**
_____ Church Related	_____ Individual	_____ State
_____ Nonprofit Association or Corporation	_____ Partnership	_____ County
_____ Other	_____ Corporation	_____ City or Municipal
	_____ LLC (Limited Liability Company)	_____ Combination
		_____ Hospital Authority

2. Information about the owner (lease or purchase agreement must be attached).
   - **A. Individuals or partnerships: Name(s), address and telephone number of each person owning any part of the governing body (please attach)**
   - **B. Non profit associations and hospital authorities: Name(s), address and telephone number of each Trustee and names of officers (please attach)**
   - **C. Corporations: Copy of charter; List of corporate officers; Names(s), address and telephone number of All owners with 10% or more stock (please attach)**
   - **D. LLC's: Certificate of Organization; List of officers; Names(s), address and telephone numbers of each Member (please attach)**

3. Real Estate property ownership. Is the building in which the facility operates owned by the licensee (governing body)?

Yes ☐ No ☐ If no, give the name, address and telephone number of the property owner:

Name _____

Address _____ Telephone _____

SECTION C: BED CAPACITY

1. Evaluated Capacity as documented by state architect _____

2. Number of beds set up for use on the date of this application: _____

SECTION D: PERSONNEL

1. Write in the number of persons in each category employed on a full-time basis.

_____ Registered Nurses	_____ Physical Therapist	_____ Food Service Personnel
_____ Licensed Practical Nurses	_____ Speech Therapist	_____ Housekeeping Personnel
_____ Registered Dietitians	_____ Social Services	_____ Administrative Personnel
_____ Certified Nursing Assistants	_____ Activities	_____ Maintenance Personnel
_____ Other (specify) _____		

2. Write in the number of **hours per week** furnished by part-time employees working in the following capacity:

_____ Registered Nurses	_____ Registered Dietitians	_____ Pharmacist
_____ Licensed Practical Nurses	_____ Physical Therapist	_____ Occupational Therapist
_____ Certified Nursing Assistants	_____ Speech Therapist	_____

SECTION E: PROVISION OF MEDICAL CARE

1. Name of the hospital(s) with which the facility has a transfer agreement (attach copy).

_____

2. Name and address of the medical director:

_____

3. Name and address of the staff dentist responsible for dental supervision of the nursing home:

_____

SECTION F: CERTIFICATION

I certify that the foregoing is true to the best of my knowledge and belief. I understand that this permit is not transferrable and any change in the above information must be reported to the Healthcare Facility Regulation Division.

_____ _____

Signature (Administrator or Authorized Representative) Title

.....

(For Department of Community Health Use Only)

Date Received: _____

Classification of Facility:

☐ Nursing Home

☐ Intermediate Care Home

APPROVED:

_____

Regional Director

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:

_____

DISCLOSURE OF OWNERSHIP AND CONTROL
Healthcare Facility Regulation Division/Long Term Care

Name of Facility: _____ **Provider Number:** _____ **Telephone #:** _____

Street Address: _____

City, County, State: _____ **Zip Code:** _____ **Date:** _____

List the names & addresses for individuals having direct or indirect ownership or a controlling interest in the entity of 5 percent or more. Continue, if necessary under remarks.

Name	Address	EIN

Type of Entity:

Non-profit
_____ Church Related
_____ Non-profit Association or Corporation
_____ Other

Proprietary
_____ Individual
_____ Partnership
_____ Corporation
_____ LLC (Limited Liability Company)

Governmental
_____ State
_____ County
_____ City or Municipal
_____ Hospital Authority

Are any owners of the disclosing entity also owners of other Nursing Homes? _____ **Yes** _____ **No**

If yes, list names, addresses of individuals and provider numbers of other nursing homes.

Name	Address	Provider Number

Has there been a change in ownership or control within the last year? _____ **Yes** _____ **No**
If yes, when? _____

Are you or do you anticipate filing for bankruptcy within the year? _____ **Yes** _____ **No**
If yes, when? _____

Is this facility operated by a management company? _____ **Yes** _____ **No**
If yes, give name of management company _____

Has there been a change in Administrator, Director of Nursing, or Medical Director with the last year? ____ **Yes** ____ **No**
If yes, give name _____

Is this facility chain affiliated? (If yes list name, address of Corporation and EIN) _____ **Yes** _____ **No**

Name	Address	EIN

List Name and address of Agent for Service

Name	Address	Telephone #

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE STATE LAWS.

Name of Authorized Representative (print or type)	Title
Signature	**Date**

Remarks: