HOSPITAL 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 Hospital 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 Hospitals 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 Hospitals 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 Hospital Regulations, surveys, plan of corrections, permits, facility letters, Administrator and/or contact information update, i.e., email address, phone numbers, email the Hospital Team at hfrd.acute@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/Relocation

1. Hospital Permit Application, signed and dated by the Owner.
2. Notarized Affidavit of Personal Identification **and** copy of photo ID
3. Certificate of Need (CON), Equipment Determination Form (EDR), or Letter of Determination from DCH, Office of Health Planning (OHP). For more information, visit DCH OHP website at: https://dch.georgia.gov/divisionsoffices/office-health-planning.

6. DCH OHP Approval of Plans
7. DCH OHP Occupancy Permit
8. Registration of Radiology equipment
9. CLIA or CLIA waiver
10. Evidence from Georgia Secretary of State that the corporation, LLC, etc. is registered, if applicable
11. Building Certificate of Occupancy from local city or county government
12. Georgia State Fire Safety Inspection or Certificate of Occupancy
13. Hospital/CAH Database Worksheet
14. Form CMS 1561 - Health Insurance Benefits Agreement
15. Form HHS 690 - Assurance of Compliance
16. Licensure fee (see Schedule of Licensure Activity Fees).

Change of Ownership (CHOW)

1. Hospital Permit Application, signed and dated by the Owner.
2. Notarized Affidavit of Personal Identification **and** copy of photo ID
3. CON from DCH OHP
4. A copy of proof of ownership/legal control of the property (deed, lease, or bill of sale)
5. 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.

6. Evidence from Georgia Secretary of State that the corporation, LLC, etc. is registered, if applicable
7. Hospital/CAH Database Worksheet
8. Form HHS 690 - Assurance of Compliance
9. Form CMS 1561 - Health Insurance Benefits Agreement

Facility Name Change

1. Hospital Permit Application signed and dated by the Owner
2. Notarized Affidavit of Personal Identification **and** copy of photo ID
3. Letter from governing board approving the name change, if applicable

Governing Body Name Change

1. Hospital Permit Application signed and dated by the Owner
2. Notarized Affidavit of Personal Identification **and** copy of photo ID
3. Evidence from Georgia Secretary of State that the corporation, LLC, etc. is registered, if applicable
4. Documentation from the governing board/attorney general or other entity approving the governing body name change as applicable.

Change in Bed Capacity

1. Hospital Permit Application signed and dated by the Owner
2. CON from DCH OHP
3. Notarized Affidavit of Personal Identification **and** copy of photo ID
4. Building Certificate of Occupancy from local city or county government (for construction)
5. Georgia State Fire Safety Inspection or Certificate of Occupancy

DEPARTMENT OF COMMUNITY HEALTH
HEALTHCARE FACILITY REGULATION DIVISION
2 MARTIN LUTHER KING JR. DR. SE
EAST TOWER, 17TH FLOOR
ATLANTA, GA 30348
404-657-5550

APPLICATION FOR A PERMIT TO OPERATE A HOSPITAL

(PLEASE TYPE or PRINT)

Pursuant to provisions of O.C.G.A. 31-7-1 et seq. Application is hereby made to operate the Hospital which is identified as follows:

SECTION A: IDENTIFICATION

Date of Application _____

Type of Application	☐ Initial	☐ Change of Ownership (CHOW)* *Entities intending to purchase a nonprofit hospital must submit evidence of approval from the state Attorney General's Office re: compliance with Georgia House of Representatives, House Bill 600 (HB600).		
	☐ Name Change	☐ Address Change	☐ Governing Body Name Change	☐ Bed Capacity Change
	☐ Services Change	☐ Provider Information Update	☐ Other _____	

Hospital Classification (Check only one): ☐ General ☐ Specialized (Type) _____

Name of Hospital

Administrator Title

Street Address City State County Zip

Phone: ( ) _____-_____ FAX: ( ) _____-_____ E-Mail Address: _____

Mailing Address (different from Street Address)

Official Name and Address of Governing Body Principal Officer of Governing Body

Name of Owner of Hospital

For Name Change or CHOW: Indicate previous name of Hospital or previous owner

Agent For Service (name) Address Phone Number

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) _____

SECTION C: BED CAPACITY

1. Total number of **State Division of Health Planning (DHP) Authorized** beds: _____
2. Bed utilization:
   - a. Number of **Acute** beds: _____ b. Number of **Psychiatric** beds: _____
   - c. Number of **Rehabilitation** beds: _____ d. Number of **Swing** beds: _____
3. Total number of beds currently staffed & set up to receive patients: _____

SECTION D: SERVICES TO BE PROVIDED (organized services only)

☐ Emergency: Trauma Level_____		☐ Surgical	☐ Open Heart Surgery
☐ Maternal & Newborn Services Level_____	☐ Neonatal	☐ Pediatrics	☐ Organ/Tissue Transplants Type_____
☐ Psychiatric Type: ☐ Child ☐ Adolescent ☐ Adult		☐ Burn Unit	☐ Nuclear Medicine

☐ Other_____

☐ Outpatient: List details below for all **off-site** services

OFF-SITE OUTPATIENT SERVICES:

TYPE OF SERVICE	ADDRESS	DISTANCE FROM HOSPITAL (MILES)

SECTION E: CERTIFICATION

I certify that this hospital will comply with all Rules and Regulations for Hospitals, Chapter 290-9-7, Chapter 290-4-4 for Residential Mental Health Facilities for Children and Youth. I further certify that the above information is true and accurate to the best of my knowledge.

Signature _____ Title _____ Date _____

For Department of Community Health Use Only

Date Received _____ **Reviewed By** _____

Classification of Hospital:

☐ General

☐ Specialized (Specify type): _____

Bed Capacity: Total Number of **DHP Authorized** beds: _____

Permit Number: _____

Effective Date: _____

Recommend Approval: _____
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:

_____ 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:

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