DRUG ABUSE TREATMENT AND EDUCATION PROGRAM 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 Drug Abuse Treatment and Education Program (DATEP) 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 Drug Abuse Treatment and Education Program 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 Drug Abuse Treatment and Education Program 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), please review Frequently Asked Questions on DCH website - https://dch.georgia.gov/divisionsoffices/hfrd/facilities-provider-information/hfrd-chow-faq .

For questions regarding DATEP Regulations, surveys, plan of corrections, permits, facility letters, Administrator and/or contact information update, i.e., email address, phone numbers, email the Behavioral Health Team at hfrd.drug@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 Permit

1. Application - completed and signed by the Owner
If a corporation - include Certificate of Incorporation and Articles of Incorporation for ALL corporations having an interest in the drug abuse treatment and education program
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 drug abuse treatment and education program
If a non-profit - include documentation of non-profit status [501(c) 3]
If Individual - include statement of all owners and percentage of ownership.
IRS Business Tax Identification Proof of Identity
2. Documentation of city or county zoning approval or applicable documents
3. Notarized Affidavit of Personal Identification **and** copy of photo ID
4. A copy of proof of ownership/legal control of the property (deed, lease, or bill of sale)
5. Fire Safety Inspection Report **or** Certificate of Occupancy performed by the state fire marshal, the proper local fire marshal or state inspector, with no violations or hazards. (**The inspection must be dated within 12 months of application submission date**).
6. Facility Floor Plan (To include areas conducive to privacy for counseling, group activities, reception/waiting

areas, and bathrooms which to ensure privacy for collection of urine specimens and/or any other areas DATEP services will be offered).
7. Certificate of Occupancy for the building
8. Provide a copy of the Clinical Laboratory Improvement Amendment Certification or Waiver (CLIA) if diagnostic drug testing is performed on-site. If testing will be performed off-site, provide a copy of the CLIA of the vendor that will be performing the drug testing.
9. Sanitation Agreement or Invoice
10. Licensure fee (see Schedule of Licensure Activity Fees).

Change of Ownership (CHOW)

1.Application - completed and signed by the Owner
If a corporation - include Certificate of Incorporation and Articles of Incorporation for ALL corporations having an interest in the drug abuse treatment and education program
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 drug abuse treatment and education program
If a non-profit - include documentation of non-profit status [501(c) 3]
If Individual - include statement of all owners and percentage of ownership.
IRS Business Tax Identification Proof of Identity
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.

Relocation

1. Application - completed and signed by the Owner
2. Documentation of city or county zoning approval or applicable documents
3. Notarized Affidavit of Personal Identification **and** copy of photo ID
4. A copy of proof of ownership/legal control of the property (deed, lease, or bill of sale)
5. Fire Safety Inspection Report **or** Certificate of Occupancy performed by the state fire marshal, the proper local fire marshal or state inspector, with no violations or hazards. (**The inspection must be dated within 12 months of application submission date**).
6. Certificate of Occupancy for the building
7. Facility Floor Plan (To include areas conducive to privacy for counseling, group activities, reception/waiting areas, and bathrooms which to ensure privacy for collection of urine specimens and/or any other areas DATEP services will be offered).
8. Provide a copy of the current DATEP license
9. Provide a copy of the Clinical Laboratory Improvement Amendment Certification or Waiver (CLIA) if diagnostic drug testing is performed on-site. If testing will be performed off-site, provide a copy of the CLIA of the vendor that will be performing the drug testing. (For new relocation address)
10. Sanitation Agreement or Invoice
11. Licensure fee (see Schedule of Licensure Activity Fees).

Initial Branch

1. Application - completed and signed by the Owner
If a corporation - include Certificate of Incorporation and Articles of Incorporation
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 drug abuse treatment and education program
If a non-profit - include documentation of non-profit status [501(c) 3]
If Individual - include statement of all owners and percentage of ownership.
IRS Business Tax Identification Proof of Identity
2. Documentation of city or county zoning approval or applicable documents
3. Notarized Affidavit of Personal Identification **and** copy of photo ID
4. A copy of proof of ownership/legal control of the property (deed, lease, or bill of sale)

5. Fire Safety Inspection Report **or** Certificate of Occupancy performed by the state fire marshal, the proper local fire marshal or state inspector, with no violations or hazards. (**The inspection must be dated within 12 months of application submission date**).
6. Facility Floor Plan to include area conducive to privacy for counseling, group activities, reception/waiting areas and bathrooms which assure privacy for collection of urine specimens and/or any other areas DATEP services will be offered.
7. Certificate of Occupancy for the building
8. Sanitation Agreement or Invoice
9. Licensure fee (see Schedule of Licensure Activity Fees).

Relocation of a Branch
1. Application - completed and signed by the Owner
2. Documentation of city or county zoning approval or applicable documents
3. Notarized Affidavit of Personal Identification **and** copy of photo ID
4. A copy of proof of ownership/legal control of the property (deed, lease, or bill of sale)
5. Fire Safety Inspection Report **or** Certificate of Occupancy performed by the state fire marshal, the proper local fire marshal or state inspector, with no violations or hazards. (**The inspection must be dated within 12 months of application submission date**).
6. Certificate of Occupancy for the building
7. Facility Floor Plan to include areas conducive to privacy for counseling, group activities, reception/waiting areas and bathrooms which assure privacy for collection of urine specimens and/or any other areas DATEP services will be offered.
9. Sanitation Agreement or Invoice
10. Licensure fee (see Schedule of Licensure Activity Fees).

Add/Remove Service(s) to the Existing Program
1. Application - completed and signed by the Owner **(The application must list the service(s) being added to or removed from the existing program).**
2**.** Notarized Affidavit of Personal Identification **and** copy of photo ID

Add Transitional Housing Unit
1. Application - completed and signed by the Owner
2. Notarized Affidavit of Personal Identification **and** copy of photo ID
3. The residential transitional housing unit address(es) must be shown on the application. If additional space is needed to record transitional units' addresses, please include a separate page.
4. A copy of the current DATEP License
5. Fire Safety Inspection Report **or** Certificate of Occupancy performed by the state fire marshal, the proper local fire marshal or state inspector, with no violations or hazards. (**The inspection must be dated within 12 months of application submission date**).
*If the transitional housing is a single dwelling, i.e., house, duplex, etc. a new fire safety inspection is required. If the transitional housing unit is in an apartment complex, an updated fire inspection report from the leasing agent/complex is required. *

Facility Name Change
1. Application - completed and signed by the Owner
2. Notarized Affidavit of Personal Identification **and** copy of photo ID

Governing Body Name Change (Not a Change of Ownership)
1. Application - completed and signed by the Owner
If a corporation - include Certificate of Incorporation and Articles of Incorporation for ALL corporations having an interest in the drug abuse treatment and education program
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 drug abuse treatment and education program
If a non-profit - include documentation of non-profit status [501(c) 3]
If Individual - include statement of all owners and percentage of ownership.
IRS Business Tax Identification Proof of Identity
2. Notarized Affidavit of Personal Identification **and** copy of photo ID
3. Provide a letter on business letterhead explaining the governing body name change and the effective date.

Decrease in Capacity

1. Application - completed and signed by the Owner
2. Notarized Affidavit of Personal Identification **and** copy of photo ID

Increase in Capacity

1. Application - completed and signed by the Owner
2. Notarized Affidavit of Personal Identification **and** copy of photo ID
3. Fire Safety Inspection Report **or** Certificate of Occupancy performed by the state fire marshal, the proper local fire marshal or state inspector, with no violations or hazards. (**The inspection must be dated within 12 months of application submission date**).
4. Facility Floor Plan (To include areas conducive to privacy for counseling, group activities, reception/waiting areas, and bathrooms which to ensure privacy for collection of urine specimens and/or any other areas DATEP services will be offered).

Change in ASAM LEVEL

1. Application - completed and signed by the Owner **(The application must indicate the new ASAM LEVEL)**
2. Notarized Affidavit of Personal Identification **and** copy of photo ID

Change in Population Served

1. Application - completed and signed by the Owner **(The application must indicate the new population served).**
2. Notarized Affidavit of Personal Identification **and** copy of photo ID

MAT Services

Please visit the portal to submit MAT Affidavit for DATEP Providers. The instructions are as follows:

1. Select Facility Type: DATEP
2. Select Application Type: MAT Affidavit for DATEP Providers
3. Upload MAT Affidavit for DATEP Providers
4. Submit

HEALTHCARE FACILITY REGULATION DIVISION
BEHAVIORAL HEALTH SECTION
2 MARTIN LUTHER KING JR. DR. SE
17TH FLOOR
ATLANTA, GA 30334

APPLICATION FOR A LICENSE TO OPERATE A DRUG ABUSE TREATMENT AND EDUCATION PROGRAM

Pursuant to provision of O.C.GA.26-5-1 et seq. Application is hereby made to operate the Drug Abuse Treatment and Education Program which is identified as follows (separate application required for each program location subject to licensure. Effective August 3, 2010, a fee must be paid for each new application, change of ownership, change of location, or renewal of license. Please follow the directions for the application below.

Section A. Identification

Type of Application: Initial _____ Renewal _____ Change of status(explain): _____

Parent: _____ Sub-units (#) _____ Branches (#) _____

Accreditation Status: (optional) Expiration date _____ Type _____

1. _____
Name of Program Phone

2. _____
Program Street Address (where services provided) City County Zip Code

3. _____
List addresses of all residential sites, including apartment numbers

4. _____
Program Mailing Address E-mail Address

5. _____
Official Name of Governing Body

6. _____
Administrator (appointed by Governing Body) Clinical Director On-site Manager

Section B. Ownership Information – Type of Ownership

Proprietary Profit	Non-Profit	
_____ Individual	_____ State	_____ Community Service Board
_____ Partnership	_____ County	_____ Church
_____ Corporation (include copy of certificate of incorporation)	_____ City	_____ Corporation
	_____ Hospital Authority	_____ Other (specify) _____
_____ Other (specify) _____		

List names and addresses of all Owners above with five percent (5%) or more interest, or officers of a corporation or partners of a partnership, as applicable (attach additional sheets if necessary)

7. _____

Section C. Programs Modalities Provided (Check all located at program address in Section A)

Outpatient _____ Amb. Detox _____ Specialized Day Treatment _____

Residential Beds: Transitional (#) _____ Intensive (#)_____ Detox _____ w/food service _____

Subunit _____ Branch (part time, a part of a full-time licensed program) _____

Parent name and license # _____
(Required for subunits and branches)

Populations served: Male _____ Female _____ Maternity (approx. #) _____

Adult _____ Adolescent _____ Children _____ Age range_____

Special Program (explain) _____

Section C. (continued)· ASAM Patient Placement Criteria

1	Outpatient services	_____	**3.3**	Clinically managed medium/high intensity residential	_____
2.1	Intensive outpatient	_____		***** Residential Subacute	_____
2.5	Partial hospitalization	_____		*****Ambulatory Detox	_____
	*****Specialized Day Treatment and Outpatient *Ambulatory detox w/ extended on-site monitoring	_____		*****Residential Intensitv	
3.1	Clinically managed low Intensity residential	_____	**3.5**	Clinically managed med/high Intensity residential	_____
	*****Residential Transitional	_____		*****Residential Intensity	_____

Section D. Personnel (assigned to program address Section A)

	# full-time	#part-time	# total hours/week
Counselor/ Therapist/ Social **Worker (certified** or licensed)	_____	_____	_____
Counselor (not **certified** or **licensed)**	_____	_____	_____
Consultants (specify type)	_____	_____	_____
Registered Nurses	_____	_____	_____
Licensed Practical Nurses	_____	_____	_____
Administrative Personnel	_____	_____	_____
Medical Director (name) _____	_____	_____	_____
Other **(specify)** _____	_____	_____	_____

Section D. Personnel (assigned to program address Section A)

Number of hours each week that Drug Treatment & Education Services are scheduled: _____

Hours each week that a physician, physician's assistant, or nurse scheduled to be present: _____

Specific days/hours of operation for the provision of Drug Treatment & Education: _____

Minimum number of program staff present during operating hours: _____

Current number of active Drug Treatment & Education Clients: _____

Services other than Drug Treatment & Education provided at this location: _____

Section F. Required Attachments

Comprehensive Program Outline (include ASAM level/s included at this location)

Proof of compliance with laws for the handling and dispensing of drugs

Proof of compliance with applicable state & local health, safety, sanitation, building & zoning codes

Affidavit of Lawful Presence in United States

Section G: Certification

I certify that this facility will comply with the Rules and Regulations for Drug Treatment & Education Programs. I understand that a license is non-transferable and must be returned to the Healthcare Facility Regulation Division if a program closes, changes location or governing body.

I certify that the above information is true to the best of my knowledge.

Signature of Principle Officer of Governing Body or Authorized Representative _____ Date of Signature _____

Printed Name of Principle Officer of Governing Body or Authorized Representative _____ Title _____

FOR STATE USE ONLY

Date Received: _____ Reviewed by: _____

Approved as: _____ Effective Dates: _____

Section / Unit Director Approval / Comments: _____

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:

_____

HFRD
Healthcare Facility Regulation Division
A Division of the Georgia Department of Community Health

Medication-Assisted Treatment (MAT) Affidavit
For
Drug Abuse Treatment and Education Program (DATEP)

Name of Facility: (DATEP Licensee)	
Name of Affiant: (Authorized Representative of Governing Body)	
Facility Address:	
COUNTY OF:	
STATE OF:	

BEFORE ME, the undersigned authority personally appeared who, being by me duly sworn, affirms as follows:

A. I, the above-named Affiant, have personal knowledge of the matters addressed in this affidavit and 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 am a duly authorized representative of the governing body of the above-named DATEP Licensee (hereinafter "DATEP") which is licensed by the Healthcare Facility Regulation Division, as a Drug Abuse Treatment and Education Program.

D. I acknowledge that DATEPs are subject to regulation pursuant to O.C.G.A. §§ 26-5-1 et *seq.,* Comp. R. & Regs.111-8-19, and Comp. R. & Regs.111-8-53, hereinafter known as the "body of controlling laws."

E. The DATEP will adhere to all rules and regulations as outlined in the body of controlling laws.

F. Buprenorphine & Suboxone will only be prescribed and dispensed by a holder of a Drug Enforcement Administration (DEA) Controlled Substance Registration Certificate permitting the holder to prescribe and dispense Schedule III medications for Opioid Use Disorder.

G. The DATEP will ensure that all Medication-Assisted Treatment (MAT) services provided by the DATEP are compliant with applicable state and federal laws and regulations.

H. The DATEP does not function as a methadone clinic which would require licensure as a Narcotic Treatment Program pursuant to O.C.G.A. § 26-5-44.

I. I understand and acknowledge that the Healthcare Facility Regulation Division will rely upon the sworn statements made herein.

_____ _____

Signature of Affiant **Date of Signature**

_____

Printed Name of Affiant

_____

Title/Position 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 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