AMBULATORY SURGICAL TREATMENT CENTER 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 Ambulatory Surgical Treatment Center (ASTC) 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 Ambulatory Surgical Treatment Center 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 Ambulatory Surgical Treatment Center 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), review Frequently Asked Questions on DCH website - https://dch.georgia.gov/divisionsoffices/hfrd/facilities-provider-information/hfrd-chow-faq .

For questions regarding ASTC Regulations, surveys, plan of corrections, permits, facility letters, Administrator and/or contact information update, i.e., email address, phone numbers, email 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

1. Application - completed, signed and dated by the Owner
2. Certificate of Need (CON), Letter of Determination or Letter of Non-Reviewability from the Department of Community Health, Office of Health Planning (DCH OHP)
3. Notarized Affidavit of Personal Identification **and** copy of photo ID that was shown to the notary public

4. DCH OHP Approval of Plans

5. DCH OHP Occupancy Permit

6. Registration of Radiology equipment or written statement if radiology equipment will not be used.

7. CLIA or CLIA waiver

8. Evidence from Georgia Secretary of State that the corporation, LLC, etc. is registered, if applicable. If not incorporated, listing of IRS tax ID number is acceptable.

9. Building Certificate of Occupancy from city or county government

10. Georgia State Fire Safety Inspection or Certificate of Occupancy (Required for Medicaid and Medicare billing). Otherwise, provide approval by the appropriate fire safety authority.

11. Form CMS 377 - Ambulatory Surgical Center Request for Certification in Medicare

12. Form CMS 370 - Health Insurance Benefits Agreement

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

Change of Ownership (CHOW)

1. Application - completed, signed and dated by the Owner

2. Certificate of Need (CON), Letter of Determination or Letter of Non-Reviewability from the Department of Community Health, Office of Health Planning (DCH OHP)

3. Notarized Affidavit of Personal Identification **and** copy of photo ID that was shown to the notary public

4. Copy of the executed legal transaction documents for the business entity (Bill of Sale, closing documents, etc.). This document 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. Evidence from Georgia Secretary of State that the corporation, LLC, etc. is registered, if applicable. If not incorporated, listing of IRS tax ID number is acceptable.

6. Form CMS 377 - Ambulatory Surgical Center Request for Certification in Medicare

7. Form CMS 370 - Health Insurance Benefits Agreement

Facility Name Change

1. Application - completed, signed and dated by the Owner

2. Letter from Board approving name change (if applicable)

3. Notarized Affidavit of Personal Identification **and** copy of photo ID that was shown to the notary public

Governing Body Name (not a change of ownership)

1. Application - completed, signed and dated by the Owner

2. Notarized Affidavit of Personal Identification **and** copy of photo ID that was shown to the notary public

3. Evidence from Georgia Secretary of State that the corporation, LLC, etc. is registered, if applicable. If not incorporated, listing of IRS tax ID number is acceptable.

Relocation

1. Application - completed, signed and dated by the Owner

2. Certificate of Need, Letter of Determination or Letter of Non-Reviewability from the Department of Community Health, Office of Health Planning (DCH OHP)

3. Notarized Affidavit of Personal Identification **and** copy of photo ID that was shown to the notary public

4. DCH OHP Approval of Plans

5. DCH OHP Occupancy Permit

6. Evidence from Georgia Secretary of State that the corporation, LLC, etc. is registered, if applicable. If not incorporated, listing of IRS tax ID number is acceptable.

7. Building Certificate of Occupancy from city or county government

8. Georgia State Fire Safety Inspection or Certificate of Occupancy (Required for Medicaid and Medicare billing). Otherwise, provide approval by the appropriate fire safety authority.

9. Form CMS 377 - Ambulatory Surgical Center Request for Certification in Medicare

10. Form CMS 370 - Health Insurance Benefits Agreement

Change in Service

1. Application - completed, signed and dated by the Owner

2. Notarized Affidavit of Personal Identification **and** copy of photo ID that was shown to the notary public

3. Letter on business letterhead explaining the change in service

Address change (not a relocation)

1. Application - completed, signed and dated by the Owner

2. Notarized Affidavit of Personal Identification **and** copy of photo ID that was shown to the notary public

3. Written documentation explaining the address change

DEPARTMENT OF COMMUNITY HEALTH
HEALTHCARE FACILITY REGULATION DIVISION
ACUTE CARE SECTION
2 PEACHTREE STREET NW
SUITE 31-447
ATLANTA, GEORGIA 30303-3142

APPLICATION FOR A PERMIT TO OPERATE AN AMBULATORY SURGICAL TREATMENT CENTER

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

SECTION A - IDENTIFICATION

Date of application: _____ Type of application: ☐ Initial ☐ Change of Ownership ☐ Address ☐ Name ☐ Scope of Services ☐ Other_____

Name of Ambulatory Surgical Center (This name will appear on Permit)

_____

Address_____City_____ County_____Zip+4 _____

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

_____

Official Name and Address of ASTC Governing Body

_____

Name of Person Delegated Responsibility for Day-to-Day Management/Administration of ASTC (regulation 290-5-35-.03 (5)

_____ Title: _____

Agent for Service/Legal Representative name: _____

Complete Address of Agent for Service/Legal Representative

Classification (check one)

☐ Single or Multi-Specialty (Certificate of Need required)

☐ Physician Owned Single Specialty (Letter of Nonreviewability required)

List Type and Scope of Surgical Services (refer to regulation 290-5-33-. 04)

_____

_____

Number of Operating Rooms	Number of Minor Procedure Rooms	Patient Capacity of Recovery Rooms
_____	_____	_____

_____

Days and Hours of Operation (for the ASTC only)

SECTION B – STAFF

List Names, Addresses, and Specialty of Professional Director and Other Physicians on the Medical Staff

Professional Director: _____

Other Physicians on the Medical Staff: _____

_____

_____

_____

SECTION C – PROVISIONS FOR CARE

List All Health Care Providers with whom the Center has Arrangements/Contracts (specify services)

Name	Service

SECTION D – OWNERSHIP INFORMATION

Type of Ownership

☐ Individual ☐ Partnership ☐ Corporation ☐ Other (specify)_____

1. List Names and Addresses of All Owners with 5% or More Interest (refer to regulation 290-5-33-.03 (2)

_____

_____

_____

2. Centers Organized as a Corporation or Partnership – List Names and Addresses of Officers of the Corporation or Principle Partners

_____

_____

_____

SECTION E– Attach Affidavit of Lawful Presence

SECTION F- CERTIFICATION

I certify that this Facility is devoted primarily to the provision of **SURGICAL** treatment to patients not requiring hospitalization and that this facility will operate in accordance with the rules and regulations governing ambulatory surgical treatment centers. I further certify that the information provided in connection with this application is true to the best of my knowledge and belief. (Refer to regulation 290-5-33-.01 (A)

_____

Signature of Principal Officer of Governing Board Title Date

(For Department Of Community Health Use Only)

_____ _____

Date Received Center Permit Number

_____ _____

Reviewed by Effective Date

Fire Safety Statement Attached: ☐ Yes ☐ No

_____

Approved Date

Copy of CON or LNR Attached: ☐ Yes ☐ No

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: • 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