ADULT DAY CENTER/ADULT DAY HEALTH SERVICE 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 Adult Day Center (ADC) or Adult Day Health Service (ADHS) 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 Adult Day Center 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 Adult Day Center 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/hfrdchowfaq.

For questions regarding ADC Regulations, surveys, plan of corrections, permits, facility letters, Administrator and/or contact information update, i.e., email address, phone numbers, email the PCH Team at pchprogram.hfrd@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. 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.
3. Documentation of city/county zoning approval or applicable documents
4. Notarized Affidavit of Personal Identification **and** copy of photo ID that was shown to the notary

public
5. A copy of proof of ownership/legal control of the property (deed, lease, or bill of sale)
6. Fire Safety Inspection Report with no violations or hazards identified from the appropriate fire safety authority showing capacity load (**inspection must be dated within 6 months of the application submission date**)
7. Floor Sketch (label all rooms, doors, windows and provide measurements for all common areas)
8. Administrator & Owner Survey Form signed and dated by the Owner (**must list all Individual Owners with 10% or more ownership interest**).
Note: If there are no individuals that own 10% or more interest, provide a letter on the company letterhead stating this information. The letter must be signed by the owner or owner representative.
9. **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 .
10. Written approval for water source and sewage disposal system, i.e., water bill with sewage charges. If the facility uses a septic system, complete the Water and Septic Tank Report Form.
11. A food service permit is required for adult day centers licensed to care for 24 or more participants.
12. A list of any other Adult Day Centers operated by the governing body.
13. If transportation services are provided, please provide proof of insurance coverage for property damage, uninsured motorist, bodily injury, and proof of vehicle registration.
14. A list of location mobile Adult Day Centers operated by the governing body (Name and Address)
15. A copy of the Registered Nurse License (A current RN license is required for Adult Day Health Service/Health Model)
16. Pictures of accessible Bathroom and Shower
17. Licensure fee (see Schedule of Licensure Activity Fees)

Change of Ownership (CHOW)

1. Application - completed, signed, and dated by the Owner
2. 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.
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. A copy of proof of ownership/legal control of the property (deed, lease, or bill of sale)
6. Administrator & Owner Survey Form signed and dated by the Owner (**must list all Individual Owners with 10% or more ownership interest**).

Note: If there are no individuals that own 10% or more interest, provide a letter on the company letterhead stating this information. The letter must be signed by the owner or owner representative.

7. **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 .

Facility Name Change

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

Governing Body Name Change (not a change of ownership)

1. Application - completed, signed, and dated by the Owner
2. 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.
3. Notarized Affidavit of Personal Identification **and** copy of photo ID that was shown to the notary public
4. Administrator & Owner Survey Form signed and dated by the Owner (**must list all Individual Owners with 10% or more ownership interest**).

Note: If there are no individuals that own 10% or more interest, provide a letter on the company letterhead stating this information. The letter must be signed by the owner or owner representative.

Decrease in capacity

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

Increase in capacity

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. Fire Safety Inspection Report with no violations or hazards identified from the appropriate fire safety authority showing capacity load (**inspection must be dated within 6 months of the application submission date**)
4. Floor Sketch (label all rooms, doors, windows and provide measurements for all common areas)

Change of Service Level from ADC to ADHC

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. A copy of the Registered Nurse License
4. Pictures of accessible Bathroom and Shower

Change of Service Level from ADHC to ADC

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.

Conversion from Personal Care Home to ADC

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. Licensure fee (see Schedule of Licensure Activity Fees)

Conversion from Community Living Arrangement to ADC

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. Licensure fee (see Schedule of Licensure Activity Fees)

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

ADULT DAY CENTER APPLICATION

Check All That Apply

o New Permit
o Change of Governing Body (ownership)
o Change of Center's Name
o Change of Address (not location)
o Change of Capacity
○ Adult Day Care ○ Adult Day Health

1. Name of Center (Area Code) Telephone

2. Home Address Street City County Zip

3. Governing Body (Area Code) Telephone

4. Home Address Street City County Zip

5. Type of Ownership o Individual o Corporation o Non-Profit o Partnership
o Church o Government o Other

6. Registered Agent for Service (for Corporation)

7. Attach the Director & Owner Survey Form.

8. Indicate if you have previously owned and operated an Adult Day Center
o No o Yes
IF YES, please indicate in space #14 where you previously operated a center.

9. Requested Capacity (specific # of participants)

10. Center or Governing Body E-mail Address

11. Change in Capacity
From To

12. Previous Governing Body

13. Previous Center Name

14. Previous Center Address

15. The above information is true and correct to the best of my knowledge. I understand that submitting false information may result in denial of my application pursuant to O.C.G.A. § 31-2-8(c)

Print Name of Owner _____ Date _____

Signature of Owner _____

Submission of the application is subject to approval by the Department.
Operating an adult day center without a license is prohibited.

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:

ADMINISTRATOR & OWNER SURVEY FORM

Name of Facility: _____ County: _____

Mailing Address: _____ City: _____ Zip: _____

NAME OF ADMINISTRATOR	DATE OF BIRTH	SOCIAL SECURITY #	ALSO OWNER? Yes / No
NAME OF OWNER(S)	**ADDRESS**	**TELEPHONE NUMBER**	**PERCENTAGE OWNERSHIP**

Owner's Signature: _____ Date: _____

01/01/2012

Water and Septic Tank Report Form

Water and sewage systems must meet applicable federal, state and local standards or regulations. This report form should be completed by the County Environmentalist from the County Public Health Department in which the facility is located if the community is served by a well and/or a septic tank. **If the community is served by public water and sewer, you only need to submit a copy of a current water bill.**

To be completed by applicant:

Facility Name: _____

Address: _____ City: _____

County: _____ Telephone: _____

To be completed by the County Environmentalist:

WATER (check only one):

_____ The facility's water supply is from an approved source.

_____ The facility's well has been tested and the report is attached.

SEWAGE (check only one):

_____ The facility is connected to a public or community sewage disposal system.

_____ The facility is served by an on-site sewage system adequate for the proposed use for _____ residents.

Maximum Number of Residents

County Environmentalist: _____ _____

Print Name Title

Signature: _____ Date: _____

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