

## PERSONAL CARE 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 Personal Care Home (PCH) application packet. As a reminder, all policies and procedures must be established as part of the requirements for regulations and readily available upon request.

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 **30 business days** from the application submission date.

The official rules for Personal Care 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 Personal Care Homes can be found on Healthcare Facility Regulation Division website at <https://dch.georgia.gov/divisionsoffices/healthcare-facility-regulation/hfr-laws-regulations>.

The online application portal can be accessed at <https://gahles.dch.georgia.gov/>. All correspondence regarding the status of your application will be sent to the email address provided for the contact person on your application. If additional documentation is required, you will receive an email from [hfrd.applicationswaivers@dch.ga.gov](mailto:hfrd.applicationswaivers@dch.ga.gov) containing a link to the application portal and a verification code. Please open the email, copy the invitation code, and paste it into the provided link to check your application status. Upload the requested documents, confirm that all documents have been uploaded, and click submit. A confirmation email will be sent, indicating that your documents will be reviewed within 14 business days. Failure to upload the requested documents will result in the denial of your application.

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 PCH 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](mailto:pchprogram.hfrd@dch.ga.gov).

For general application questions, email the HFRD Applications and Waivers Team at [hfrd.applicationswaivers@dch.ga.gov](mailto: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. Evidence from Georgia Secretary of State that the corporation, LLC, etc. Is registered, if applicable. If not applicable, provide other supporting documentation showing legal authority.
2. Documentation of city/county zoning approval or applicable documents
3. Notarized Affidavit of Personal Identification

4. 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 by the appropriate fire safety authority showing capacity load (**inspection must be dated within 12 months of the application submission date**). A sprinkler system is required for 7 or more beds.
  7. Electrical Inspection Compliance Form with no violations or hazards identified from a Georgia licensed electrician and the electrician's State license number (**inspection must be dated within 6 months of the application submission date**).
  8. Floor Sketch (label all rooms, bedroom measurements, location of all doors, windows and bed placement for residents, provider's personal living quarters, and staff)
  9. 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.**
10. **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](mailto:gchexs.user@dch.ga.gov).
  11. 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. If the water is not provided by the city or county water system, provide a copy of a current water test (**test must be dated within 6 months of application submission date**).
  12. A Letter of Determination approved by the Office of Health Planning (OHP) for 25 or more beds. For more information, visit DCH OHP website at <https://dch.georgia.gov/con-applications-and-forms>.
  13. Notarized Affidavit of Financial Stability for 25 or more beds
  14. Licensure fee (see Schedule of Licensure Activity Fees)

### **Change of Ownership (CHOW)**

1. Evidence from Georgia Secretary of State that the corporation, LLC, etc. is registered, if applicable. If not applicable, provide other supporting documentation showing legal authority.
  2. Notarized Affidavit of Personal Identification
  3. Copy of photo ID that was shown to the notary public
  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.). 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.**
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 Georgia 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](mailto:gchexs.user@dch.ga.gov).

8. Notarized Affidavit of Financial Stability for 25 or more beds.

#### **Governing Body Name Change (not a Change of Ownership)**

1. Evidence from Georgia Secretary of State that the corporation, LLC, etc. Is registered, if applicable. If not applicable, provide other supporting documentation showing legal authority.
2. Notarized Affidavit of Personal Identification
3. 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.**

#### **Facility Name Change**

1. Notarized Affidavit of Personal Identification
2. Copy of photo ID that was shown to the notary public

#### **Decrease in Bed Capacity**

1. Notarized Affidavit of Personal Identification
2. Copy of photo ID that was shown to the notary public

#### **Increase in Bed Capacity**

1. Notarized Affidavit of Personal Identification
2. 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 12 months of the application submission date**). A sprinkler system is required for 7 or more beds.
4. Floor Sketch (label all rooms, bedroom measurements, location of all doors, windows and bed placement for residents, family, and staff)
5. A Letter of Determination approved by DCH Office of Health Planning (OHP) for 25 or more beds. For more information, visit DCH OHP website at <https://dch.georgia.gov/con-applications-and-forms>.
6. Electrical Inspection Compliance Form with no violations or hazards identified from a Georgia licensed electrician and the electrician's State license number (**inspection must be dated within 6 months of the application submission date**). **This form is only required if the facility has made structural changes.**

#### **Conversion from Personal Care Home to Assisted Living Community (minimum bed capacity of 25)**

1. Notarized Affidavit of Personal Identification
2. Copy of photo ID that was shown to the notary public
3. Fire Safety Inspection Report with no violations or hazards identified from the Georgia State Fire Marshal's Office showing capacity load (**inspection must be dated within 12 months of application submission date**).
4. Pictures of the ALC's exterior, a common area and a typical resident room (1 picture of each)
5. Key People 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.**

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

#### **Conversion from Personal Care Home to Community Living Arrangement**

1. Notarized Affidavit of Personal Identification
2. Copy of photo ID that was shown to the notary public
3. Licensure fee (see Schedule of Licensure Activity Fees).

#### **Conversion from Personal Care Home to Adult Day Center**

1. Notarized Affidavit of Personal Identification
2. Copy of photo ID that was shown to the notary public
3. Documentation of city/county zoning approval or applicable documents
4. Fire Safety Inspection Report with no violations or hazards identified by the appropriate fire safety authority showing capacity load (**inspection must be dated within 12 months of the application submission date**).
5. Floor Sketch (label all rooms, doors, windows and provide measurements for all common areas)
6. Pictures of accessible Bathroom and Shower
7. A food service permit is required for adult day centers licensed to care for 24 or more participants.
8. A copy of the Registered Nurse License (A current RN license is required for Adult Day Health Service/Health Model)
9. Licensure fee (see Schedule of Licensure Activity Fees)

#### **Memory Care Certification**

**Before you apply for a memory care certification, you must have a Personal Care Home permit.**

1. Notarized Affidavit of Personal Identification
2. Copy of photo ID that was shown to the notary public
3. Notarized Affidavit of Compliance

**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:



2 Martin Luther King Jr. Dr. SE 17th fl. | Atlanta, GA 30334 | 404-657-5700 | www.dch.georgia.gov

AFFIDAVIT OF COMPLIANCE

I, \_\_\_\_\_, the undersigned duly authorized representative of
Name of Owner/Applicant

\_\_\_\_\_, hereby attest that in furtherance of its application
Governing Body Name

for licensure, said entity has developed policies and procedures mandated under the
rules and regulations indicated below. If the application for licensure is approved by the
Department, these policies and procedures shall be implemented immediately by the
facility. Additionally, \_\_\_\_\_ understands that once licensed, it is
Governing Body Name

subject to unannounced periodic inspections at which time the policies and procedures
shall be readily available for review for sufficiency and compliance with applicable
rules and regulations. Deficient policies and procedures may subject the facility to
sanctions pursuant to Ga. Comp. R. & Regs. 111-8-25.

- 1) \_\_\_\_\_ Assisted Living Communities
Chapter 111-8-63
2) \_\_\_\_\_ Home Health Agencies
Chapter 111-8-31
3) \_\_\_\_\_ Hospices
Chapter 111-8-37
4) \_\_\_\_\_ Narcotic Treatment Programs
Chapter 111-8-53



**GEORGIA DEPARTMENT  
OF COMMUNITY HEALTH**

- 5) \_\_\_\_\_ Personal Care Homes  
Chapter 111-8-62
  
- 6) \_\_\_\_\_ Private Home Care Providers  
Chapter 111-8-65

This \_\_\_\_ day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
Signature of Authorized Representative

\_\_\_\_\_  
Business/Facility Name

SUBSCRIBED AND SWORN  
BEFORE ME ON THIS THE  
\_\_ DAY OF \_\_\_\_\_ 20\_\_

\_\_\_\_\_  
NOTARY PUBLIC  
My Commission Expires:

## Affidavit Of Financial Stability

*Required for both Initial Applications and CHOW Applications for Licensure for ALC and PCH of 25 beds or more.*

<b>Name of Applicant for Facility Licensure:</b>	
<b>Facility Address:</b>	
<b>Name of Certified Public Accountant (CPA):</b>	
<b>Business Affiliation of CPA (if applicable):</b>	
<b>CPA Firm License # (if applicable):</b>	
<b>CPA License/Certificate #:</b>	
<b>Mailing Address of CPA:</b>	
<b>Email address of CPA:</b>	
<b>Phone Number of CPA:</b>	

**COUNTY OF:** \_\_\_\_\_

**STATE OF:** \_\_\_\_\_

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

- 1) I have personal knowledge of the matters addressed in this affidavit the attestations made herein.
- 2) 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.
- 3) I am a Certified Public Accountant, and I am licensed in the State of \_\_\_\_\_ and my license is currently active and in good standing. My license number is \_\_\_\_\_. If I am not licensed in the State of Georgia, my firm is actively licensed with the Georgia State Board of Accountancy, and I have provided the license information above.
- 4) I understand and acknowledge that the above-referenced applicant for facility licensure is requesting authority from the Georgia Department of Community Health (the "Department") to operate a personal care home or assisted living community that will provide personal care services to elderly and/or disabled individuals in the State of Georgia and that there are individuals under care of the facility that may be vulnerable and in need of trustworthy oversight.



5 A)  In executing this affidavit, I hereby swear or affirm that I have reviewed financial documents<sup>1</sup> for the previous fiscal year, for the above-referenced applicant for facility licensure.

**OR**

5 B)  In executing this affidavit, I hereby swear or affirm that, in the absence of the documents in 5A above, I have reviewed sufficient financial documents to make the required determination for the above-referenced applicant for facility licensure. Sufficient financial documents may include forward-looking documents.<sup>2</sup>

6) In executing this affidavit, I hereby swear or affirm that, based on my review of the applicant's documents pursuant to 5A or 5B above, the applicant for facility licensure has demonstrated the financial resources to operate. I understand that the Department will rely on the statements made herein in making a determination regarding the applicant's eligibility for facility licensure.

\_\_\_\_\_  
**Signature of Certified Public Accountant**

\_\_\_\_\_  
**Date of Signature**

\_\_\_\_\_  
**Printed Name of Certified Public Accountant**

SUBSCRIBED AND SWORN BEFORE ME ON

THIS THE \_\_\_\_\_ DAY OF \_\_\_\_\_ 20 \_\_\_\_\_

Notary Public

My Commission Expires: \_\_\_\_\_

<sup>1</sup> While this list is not exhaustive, said reviewed documents may include audited or unaudited documents such as Bank Statements, Personal Tax Returns, Business Tax Records, Invoices, Receipts, Income Statements, Balance Sheets, Profit and Loss Statements, Balance Sheets, Cash-flow Statements, Accounts Receivable/Accounts Payable, and Aging Reports.

<sup>2</sup> A Pro Forma Statement or financial forecast consists of prospective financial statements that present, to the best of the applicant's knowledge and belief, an entity's expected financial position, results of operations, and cash flows. A Projected Income Statement is a snapshot of applicant's forecasted sales, cost of sales, and expenses.

# ELECTRICAL INSPECTION COMPLIANCE FORM

NAME OF COMMUNITY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

OWNER: \_\_\_\_\_

OWNER'S CURRENT ADDRESS: \_\_\_\_\_

OWNER'S PHONE #: \_\_\_\_\_

OWNER'S EMAIL ADDRESS: \_\_\_\_\_

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## TO BE COMPLETED BY THE ELECTRICIAN

**NOTE TO ELECTRICIAN: Do NOT complete this form unless all information is listed above regarding the location to be inspected.**

I, \_\_\_\_\_ have inspected the electrical system at the above listed community and have determined that the electrical system is maintained in a safe condition and is free of hazards.

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date of Inspection: \_\_\_\_\_

Georgia State License #: \_\_\_\_\_

Phone #: \_\_\_\_\_

# 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.**

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## 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

<b>Licensure Activity</b>	<b>Fee</b>	<b>Frequency</b>
Application Processing Fees: <ul style="list-style-type: none"> <li>• New Application</li> <li>• Change of Ownership</li> <li>• Change in Service Level (Requiring on site visit)</li> <li>• Name Change</li> </ul>	\$300	Upon submission
Initial License Fee (Same as annual licensure activity fee for each program type)	Varies by program	Submitted prior to issuance of license
Involuntary Application Processing fee after unlicensed complaint investigation	\$550	
Follow-up visit to periodic inspection	\$250	License renewal date
<b>License Type</b>	<b>Fee</b>	<b>Frequency</b>
<b>Adult Day Centers</b>		
Social Model	\$250	Annually
Medical Model	\$350	Annually
<b>Ambulatory Surgical Treatment Centers (ASC)*</b>	\$750	Annually
<b>Assisted Living Communities (ALC)</b>		
25 to 50 beds	\$750	Annually
51 or more beds	\$1,500	Annually
<b>Birthing Centers</b>	\$250	Annually
<b>Community Living Arrangements*(CLA)</b>	\$350	Annually
<b>Drug Abuse Treatment Programs* (DATEP)</b>	\$500	Annually
<b>End Stage Renal Disease Centers (ESRD)</b>		
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
<b>Home Health Agencies*(HHA)</b>	\$1,000	Annually
<b>Hospices*(HSPC)</b>	\$1,000	Annually
<b>Hospitals*</b>		
1 to 24 beds	\$250	Annually
25 to 50 beds	\$750	Annually
51 or more beds	\$1,500	Annually
<b>ICFMRs - Intermediate Care Facilities / MR (private)</b>	\$250	Annually
<b>Narcotic Treatment Programs (NTP)</b>	\$1,500	Annually
<b>Memory Care Certificate</b> for Assisted Living/Personal Care Homes	\$200	Annually



<b>Nursing Homes</b>		
1 to 99 beds	\$500	Annually
100 or more beds	\$750	Annually
<b>Personal Care Homes (PCH)</b>		
2 to 24 beds	\$350	Annually
25 to 50 beds	\$750	Annually
51 or more beds	\$1,500	Annually
<b>Private Home Care Providers*(PHCP)</b>		
	Per Service	
Companion Sitting	\$250	Annually
Personal Care Services	\$250	Annually
Nursing Services	\$250	Annually
<b>Traumatic Brain Injury Facilities</b>		
	\$250	Annually
<b>X-ray Registration</b>		
	\$300	Initial Registration Only
<b>MISCELLANEOUS FEES</b>		
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
Returned Check Charge- as assessed by bank	< \$50	Per instance
<b>ACCREDITATION DISCOUNT INFORMATION</b>		
<p><b>*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.</b></p>		
<b>Accreditation Organization</b>		<b>Program</b>
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
Center for Improvement in Healthcare Quality (CIHQ)		Hospital
Commission on the Accreditation of Rehabilitation Facilities (CARF)		CLA, DATEP, PHCP
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, DATEP, HHA, Hospice, Hospital, PHCP