HOSPICE APPLICATION CHECKLIST
(Application changes for providers with current permits)

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 Hospice 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 Hospice 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 Hospice 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 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 Hospice Regulations, surveys, plan of corrections, permits, facility letters, Administrator and/or contact information update, i.e., email address, phone numbers, email the Hospice Team at hfrd.hospicehh@dch.ga.gov .

Note: Application fees are non-refundable. All licensure fees must be paid in full prior to receiving a permit or license.

Addition of Services

1. Notarized Affidavit of Personal Identification
2. Copy of photo ID that was shown to the notary public
3. Provide a letter on business letterhead requesting the type of service(s)
4. Provide an update of your policies that reflect the addition of services (Please refer to the regulations).

Branch Addition

1. Notarized Affidavit of Personal Identification
2. Copy of photo ID that was shown to the notary public
3. Provide a letter on business letterhead indicating the parent agency the branch will be billing under and the counties the branch will be servicing. If the branch serves counties currently not authorized under the parent agency, list the additional counties.
4. Notarized Affidavit for Hospice Nursing Services and County Approval

Name Change (Doing Business as Only)

1. Notarized Affidavit of Personal Identification
2. Copy of photo ID that was shown to the notary public
3. Provide a letter on business letterhead explaining the change and the effective date.

Governing Body Name Change (Not a Change of Ownership)

1. Notarized Affidavit of Personal Identification
2. 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 applicable, provide other supporting documentation showing legal authority.
4. Provide a letter on business letterhead explaining the change and the effective date.

Relocation

1. Notarized Affidavit of Personal Identification
2. Copy of photo ID that was shown to the notary public
3. Notarized Affidavit for Hospice Nursing Services and County Approval
4. If new location, provide a letter on business letterhead explaining if this will impact current patients being served. If so, please provide a plan that shows how the agency will accommodate the patient(s).

Service Area Changes (add or remove counties)

1. Notarized Affidavit of Personal Identification
2. Copy of photo ID that was shown to the notary public
3. Provide a letter on business letterhead indicating counties that are currently being served, and counties that need to be added or removed.
4. If the updated county will impact current patients being served, please provide a plan that shows how the agency will accommodate the patient(s).
5. Notarized Affidavit for Hospice Nursing Services and County Approval

In-patient Unit (IPU) - Decrease in bed capacity

1. Notarized Affidavit of Personal Identification
2. Copy of photo ID that was shown to the notary public
3. Provide a letter on business letterhead indicating which parent agency the IPU operates under.

In-patient Unit (IPU) - Increase in bed capacity

1. Notarized Affidavit of Personal Identification
2. Copy of photo ID that was shown to the notary public
3. Provide a letter on business letterhead indicating which parent agency the IPU operates under.
4. Floor plan showing expansion for bed increase
5. Certificate of Occupancy from State Fire Marshal's office

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:

_____

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Georgia Department of Community Health Healthcare Facility Regulation Division

Affidavit for Hospice Nursing Services and County Approval

Name of Parent Facility (Licensee)	
Name of Affiant (Authorized Representative of Parent Facility governing body):	
Parent Facility Address:	

COUNTY OF: _____

STATE OF: _____

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

A. I, the above-named Affiant, have personal knowledge of the matters addressed in this affidavit 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 swear or affirm that I am a duly authorized representative of the governing body of above-named Parent Facility located at the above listed address which is currently licensed through the Healthcare Facility Regulation Division, as a Hospice, as pursuant to and defined in O.C.G.A. §§ 31-7-170*et seq.* Short Title known as the Georgia Hospice Law, and Ga. Comp. R. & Regs.111-8-37 Rule and Regulations for Hospices (hereinafter known to as the governing body of law and regulations.)

D. I swear or affirm that the Licensee has _____ (total number of facilities) located at:

1. _____
2. _____
3. _____

Use additional sheets if necessary.

E. Pursuant to the aforementioned body of laws, the Affiant requests to provide hospice services to the following county(s):

1.	2.	3.
4.	5.	6.
7.	8.	9.

Use additional sheets if necessary.

F. I understand that on-site nursing services must be available within one hour of notification where terminally ill patients or the patient with an advanced and progressive disease who has contracted for nursing services experiences a symptom management crisis situation.

G. I understand the Hospice must be able to present, when requested, documentation including date and time received of each notification or request where a terminally ill patient or patient with an advanced progressive disease request nursing services and document the nurse's on-site arrival time.

H. I understand the Hospice must maintain an on-call log for all calls received after normal business hours, the log record must contain, but not be limited to, the of name of caller, date and time of the call, arrival time of the nurse to the residence, and the purpose of the call. These records must be kept for a minimum of two (2) years as defined by the governing body of laws.

I. I understand that Licensee must remain in substantial compliance with the Healthcare Facility Regulation Division, Rules, and Regulations for the Hospice to maintain licensed access to the requested counties, and that such license may be disciplined by citations, fines, and up to revocation by Healthcare Facility Regulation Division for Licensee's failure to substantially comply with the Rules.

J. I hereby submit this Affidavit for the Healthcare Facility Regulation Division's consideration to grant licensed access for the counties referenced above to the above-named Licensee.

K. I understand and acknowledge that the Healthcare Facility Regulation Division will rely upon the sworn statements made herein in making a determination regarding the licensed access to service the counties requested.

_____ _____

Signature of Affiant **Date of Signature**

_____

Printed Name of Affiant

SUBSCRIBED AND SWORN BEFORE ME ON

THIS THE_____DAY OF_____20_____

Notary Public

My Commission Expires: _____

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

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 after unlicensed complaint investigation	$550	
Follow-up visit to periodic inspection	$250	License renewal date
License Type	**Fee**	**Frequency**
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
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
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

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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 Registration 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
Returned Check Charge- as assessed by bank	< $50	Per instance

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
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