HOSPICE 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 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), see 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 .

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

3. Notarized Affidavit of Compliance (**Select Hospice**)
4. Notarized Affidavit for Hospice Nursing Services and County Approval
5. **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 .

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

6. Copy of Business License from local city/county government. The business license must be current with the facility name and address. If you are unable to obtain a business license, provide a written explanation from your local government stating the reason.
7. 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.
8. Hospice budget plan for 1st year.
9. Description of services as defined by the Governing Body. **Rule 111-8--37-.07 (1)-(6)**
10. Designation of the individual responsible to act for the administrator during any period the administrator is absent and the individual responsible for the Quality Management program**. Rule111-8-37-07 (5)(f)**
11. Staff list, indicating whether employed, contracted, or volunteer.
12. Name, qualifications, and signed job description (including copy of professional license if applicable) of administrator. Meets qualification requirements of either (check): Licensed healthcare professional with one year supervisory or management exp. in a hospice setting; or Education, training, and experience in health service administration with two years supervisory or management Experience in a hospice setting.

Job duties requirements must include:
-Ensures that policies are developed w/ the IDT team
-Ensure employment of qualified staff
-Ensures policies and procedures are implemented
-Ensures a qualified DON and sufficient staff
-Ensures there is an orientation, training, & supervision for every employee and that they complete these programs
-Ensures that there are effective communication mechanisms for staff, patients, and families.

13. Names, qualifications, and signed job descriptions for all staff members, including verification of licensure where applicable.
14. Copy of orientation curriculum. Hospice concepts and philosophy Patient Rights Hospice policies and procedures includes Reporting of abuse and neglect, disaster preparedness, and fire safety and emergency evacuations. **Rule 111-8-37-.13(2)**
15. Evidence of an initial health screening for each employee and volunteer completed by a MD, DO, NP, or PA, TB screening and Hepatitis vaccinations or signed documentation of refusal/declination. **Rule 111-8-37-.13(5)**
16. Copies of any contracts for professional services from independent contractors.
17. Copy of procedure for reporting abuse or neglect requirement for employees/volunteers.
18. Confirmation that all employees/volunteers have completed abuse or neglect training. **Rule 111-8-37-.13(4)**

19. A signed statement from a licensed pharmacist (GA License) that policies and procedures for management of drugs and biologicals have been reviewed and approved. Provide a copy of the pharmacist's license. **Rule 111-8-37-.21 (2)(a)**
20. 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. Copy of the executed legal transaction documents for the business entity (Bill of Sale, closing documents, etc.). This 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.

3. Organizational charts of the governing body pre- and post-sale transaction
4. Copy of Business License from local city/county government. The business license must be current with the facility name and address. If you are unable to obtain a business license, provide a written explanation from your local government stating the reason.
5. Notarized Affidavit of Personal Identification
6. Copy of photo ID that was shown to the notary public
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 .

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

New Hospice Inpatient Unit (IPU) or Residential Unit

1. Submit the floor plan for review by this office
2. An attestation statement indicating that the IPU site will be owned and operated by the same governing body and that one medical director will assume responsibility for the medical component at this location
3. Attach organizational chart delineating lines of authority, professional and administrative control for the hospice and the additional site
4. Notarized Affidavit of Personal Identification
5. Copy of photo ID that was shown to the notary public

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:

____

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

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 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.

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Georgia Department of Community Health Healthcare Facility Regulation Division

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

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

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