

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.

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 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 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 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. Certificate of Need (CON), Letter of Determination or Letter of Non-Reviewability from the Department of Community Health, Office of Health Planning (DCH OHP)
2. Notarized Affidavit of Personal Identification
3. 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 applicable, provide other supporting documentation showing legal authority.
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. Certificate of Need (CON), Letter of Determination or Letter of Non-Reviewability from the Department of Community Health, Office of Health Planning (DCH OHP)
2. Notarized Affidavit of Personal Identification
3. 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 applicable, provide other supporting documentation showing legal authority.
6. Form CMS 377 - Ambulatory Surgical Center Request for Certification in Medicare
7. Form CMS 370 - Health Insurance Benefits Agreement

Facility Name Change

1. Letter from Board approving name change (if applicable)
2. Notarized Affidavit of Personal Identification
3. Copy of photo ID that was shown to the notary public

Governing Body Name (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.

Relocation

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

3. 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 applicable, provide other supporting documentation showing legal authority.
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. Notarized Affidavit of Personal Identification
2. Copy of photo ID that was shown to the notary public
3. Letter on business letterhead explaining the change in service

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: <ul style="list-style-type: none"> New Application Change of Ownership Change in Service Level (Requiring on site visit) Name Change 	\$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
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



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		
<p>*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.</p>		
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