**END STAGE RENAL DISEASE FACILITY 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 End Stage Renal Disease (ESRD) Facility 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 End Stage Renal Disease Facilities 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 End Stage Renal Disease Facilities 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 ESRD Regulations, surveys, plan of corrections, permits, facility letters, Administrator and/or contact information update, i.e., email address, phone numbers, email hfrd.specialized@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. 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. CMS 3427
5. Attestation Form for Medicare Certification Purpose
6. CMS 855 approval letter (required by the program after an initial licensure survey)
7. Licensure fee Licensure fee (see Schedule of Licensure Activity Fees).

**Change of Ownership (CHOW)**

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. CMS 3427
5. Attestation Form for Medicare Certification Purpose
6. 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.***

7. CMS 855 approval letter (required upon application submission)

**Relocation**

1. Notarized Affidavit of Personal Identification
2. Copy of photo ID that was shown to the notary public
3. Letter from facility requesting change, provide the old and new addresses and the expected relocation date
4. CMS 855 approval letter (required upon application submission)

**Facility Name Change**

1. Notarized Affidavit of Personal Identification
2. Copy of photo ID that was shown to the notary public
3. Letter from facility requesting the change
4. CMS 855 approval letter (required upon application submission)

**Change in Stations(add/remove)**

1. Notarized Affidavit of Personal Identification
2. Copy of photo ID that was shown to the notary public
3. Letter from facility requesting change
4. CMS 3427

**Change in Services**

1. Notarized Affidavit of Personal Identification
2. Copy of photo ID that was shown to the notary public
3. Letter explaining the requested change(s)
4. CMS 3427

**Georgia Department of Community Health**
**Healthcare Facility Regulation Division**
**2 Martin Luther King Jr. Dr. SE, East Tower 17th Floor**
**Atlanta, Georgia 30334**
**404-657-5850**
**www.dch.georgia.gov**

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**Instructions: Complete form and submit with application to Healthcare Facility Regulation Division if facility qualifies for exemption as outlined below.**

**ATTESTATION STATEMENT FOR MEDICARE CERTIFICATION PURPOSE**

**Life Safety Code Attestation for Exempt End Stage Renal Disease (ESRD) Facilities**

Facility Name: _____ CCN: _____

Facility Address: _____

_____

_____

I attest to the following:

☐ The above named facility provides one or more exits to the outside at grade level from the patient treatment level. ***(Note that the patients' exit path from the treatment area may include an accessibility ramp that complies with the Americans with Disabilities Act (ADA));***

AND

☐ The above named facility is not adjacent to high hazardous occupancy. ***(Note: This type of occupancy is defined in The National Fire Protection Association (NFPA) Life Safety Code 101, 2000 Edition at § A.3.3.134.8.2 as "occupancies where gasoline and other flammable liquids are handled, used, or stored under such conditions that involve possible release of flammable vapors; where grain dust, wood, or plastic dusts, aluminum or explosives are manufactured, stored, or handled; where cotton or other combustible fibers are processed or handled under conditions that might produce flammable flying; and where other situations of similar hazard exist.")***

The facility agrees to notify the Centers for Medicare & Medicaid Services (CMS) if there are any structural changes that would cause the facility to no longer meet the exemption requirements.

_____ _____

Signature of Facility Administrator: Date:

# 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

# Schedule of Licensure Activity Fees

| Licensure Activity | Fee | Frequency |
|---|---|---|
| Application Processing Fees:<br>• New Application<br>• Change of Ownership<br>• Change in Service Level (Requiring on site visit)<br>• Name Change | $300 | Upon submission |
| Initial License Fee<br>(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**<br>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 |