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 timeframe 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/.

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_do_not_reply@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 link provided to check your application status. Upload the requested documents, confirm that all documents have been uploaded, and click submit. You will receive a confirmation email acknowledging that we have received your documents. 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 about the ESRD Regulations, surveys, plan of corrections, permits, facility letters, administrator and/or contact information updates, i.e., email address, phone numbers, email the Specialized Care Team at 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. The licensure fee will be collected by the program after the application review is complete. If you encounter payment issues during the application process, email the Finance Team at hfrd.payments@dch.ga.gov for assistance.

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. Complete the electronic Owner Form. List all individual owners if applicable. This form must be signed and dated by the Owner.
5. CMS 3427 ESRD Application and Survey and Certification Report
6. Attestation Form for Medicare Certification Purpose
7. CMS 855 approval letter (required by the program after an initial licensure survey)

8. Licensure fee Licensure fee - see Schedule of Licensure Activity Fees
https://dch.georgia.gov/divisionsoffices/hfrd/hfrd-payment-portal

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. Complete the electronic Owner Form. List all individual owners if applicable. This form must be signed and dated by the Owner.
3. Notarized Affidavit of Personal Identification
4. Copy of photo ID that was shown to the notary public
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. CMS 3427 ESRD Application and Survey and Certification Report
7. Attestation Form for Medicare Certification Purpose
8. CMS 855 approval letter

Governing Body Name Change (not a 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. CMS 3427 ESRD Application and Survey and Certification Report
5. CMS 855 approval letter

Relocation

1. Letter from facility requesting change, provide the old and new addresses and the expected relocation date
2. CMS 3427 ESRD Application and Survey and Certification Report
3. CMS 855 approval letter (required by the program prior to survey)

Facility Name Change

1. Letter from facility requesting the change
2. 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.
3. CMS 855 approval letter

Change in Station (add)

1. Notarized Affidavit of Personal Identification
2. Copy of photo ID that was shown to the notary public
3. Letter from facility requesting change(s)
4. CMS 3427 ESRD Application and Survey and Certification Report

Change in Station (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(s)
4. CMS 3427 ESRD Application and Survey and Certification Report

Change in Service (add)

1. Letter explaining the requested change(s)
2. CMS 3427

Change in Service (remove)

1. Letter explaining the requested change(s)
2. 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

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:

_____