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 timeframe 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/.

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 provided link 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), 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 Home Care 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. 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. Notarized Affidavit of Compliance (**Select Hospice**)
4. Notarized Affidavit for Hospice Nursing Services and County Approval
5. Complete the electronic Owner Form. List all individual owners if applicable. This form must be signed and dated by the Owner.
6. **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.

7. 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.
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. Hospice budget plan for 1st year.
10. Description of services as defined by the Governing Body. **Rule 111-8--37-.07 (1)-(6)**
11. 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)**
12. Staff list, indicating whether employed, contracted, or volunteer.
13. 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 experience 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.

14. Names, qualifications, and signed job descriptions for all staff members, including verification of licensure where applicable.
15. Copy of orientation curriculum including hospice concepts and philosophy, patient rights, hospice policies and procedures. It must also include reporting of abuse and neglect, disaster preparedness, fire safety, and emergency evacuations. **Rule 111-8-37-.13(2)**
16. Evidence of an initial health screening for each employee and volunteer completed by a MD, DO, NP, or PA. A TB screening and Hepatitis vaccinations or signed documentation of refusal/declination is also required. **Rule 111-8-37-.13(5)**
17. Copies of any contracts for professional services from independent contractors.
18. Copy of procedure for reporting abuse or neglect requirement for employees/volunteers.
19. Confirmation that all employees/volunteers have completed abuse or neglect training. **Rule 111-8-37-.13(4)**
20. 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)**
21. CMS 417 Hospice Request for Certification in Medicare
22. HHS 690 Assurance of Compliance https://ocrportal.hhs.gov/ocr/aoc/instruction.jsf
23. CMS 1561 Health Insurance Benefit Agreement

24. 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. 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 ownership structure for 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. Complete the electronic Owner Form. List all individual owners if applicable. This form must be signed and dated by the Owner.
8. **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.

9. HHS 690 Assurance of Compliance https://ocrportal.hhs.gov/ocr/aoc/instruction.jsf
10. CMS 1561 Health Insurance Benefit Agreement

New Hospice Inpatient Unit (IPU)

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
6. Georgia State Fire Safety Inspection and/or Certificate of Occupancy
7. Provide a letter on the facility's letterhead indicating which parent agency the IPU will operate under and include the addresses for both the parent and IPU in the letter.

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

Branch Removal

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 branch location that will be removed
4. Notarized Affidavit for Hospice Nursing Services and County Approval

Facility 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 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. 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. 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 Change (add 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.
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

Service Area Change (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 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. Provide a copy of the facility floor plan that indicates where the additional beds are located and the location of any building construction or renovation.
5. Certificate of Occupancy from State Fire Marshal's office

Change in Service (add)

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) that will be added.
4. Provide an update of your policies that reflect the addition of services (Please refer to the regulations).

Change in Service (remove)

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) that will be removed.

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:

_____ I am a United States citizen.

_____ I am a legal permanent resident of the United States.

_____ 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 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

Brian P. Kemp, Governor **Russel Carlson, Commissioner**

2 Martin Luther King Jr. Dr. SE, East Tower, 17th fl. | Atlanta, GA 30334 | 404-657-5700 | www.dch.georgia.gov

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:

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: _____