PRIVATE HOME CARE PROVIDERS 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 Private Home Care Providers (PHCP) 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 Private Home Care Providers 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), review Frequently Asked Questions on DCH website - https://dch.georgia.gov/divisionsoffices/hfrd/facilities-provider-information/hfrd-chow-faq .

For questions regarding PHCP Regulations, adding counties to an existing permit, surveys, plan of corrections, permits, facility letters, administrator and/or contact information update, i.e., email address, phone numbers, email the Private Home Care Team at hfrd.phcp@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 Private Home Care Providers)**
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. 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. Complete the electronic Owner Form. List all individual owners if applicable. This form must be signed and dated by the Owner.
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 the company letterhead stating this information. The letter must be signed by the owner or owner's representative.

The Administrator and at least one other employee are required to open a PHCP. A Registered Nurse (RN) is permitted to hold the position as an Administrator, Owner, and Certified Nursing Assistant (CNA).

8. Name, qualifications, and job description (including copy of professional license, if applicable) for the Administrator (Rule 111-8-65-.09. Administration and Organization).
9. Administrator - Evidence of Administrator having a history of no misconduct as described in 111-8-65-.09(3)(a)1. This written statement must be signed and dated by the employee.
10. Administrator - Job duties include full authority and responsibility for the operation of the PHCP as described in 111-8-65- .09(3). The job duties must be signed and dated by the employee.
11. Administrator - **Satisfactory determination letter, dated within 12 months of the application submission date**, from the DCH Georgia Criminal History Check System (GCHEXS). For a list of exempted professional healthcare providers, visit DCH OIG.
12. Administrator- Evidence of completion of orientation training as described in 111-8-65-.09(6)(a). The orientation training must include items #1 through #4, signed and dated by the Administrator.
13. Registered Nurse - Copy of current Georgia Registered Nurse License
14. Registered Nurse - Evidence of Registered Nurse having a history of no misconduct as described in 111-8-65-.09(5)(a)1. This written statement must be signed and dated by the employee.
15. 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 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. Copy of Business license from your local city or 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.
4. Notarized Affidavit of Personal Identification
5. Copy of photo ID that was shown to the notary public
6. Notarized Affidavit of Compliance **(select Private Home Care Providers)**
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 the company letterhead stating this information. The letter must be signed by the owner or owner representative.

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. Notarized Affidavit of Compliance **(select Private Home Care Providers)**

Facility Name Change
1. If name of the business and governing body is the same, upload a copy of the Georgia Secretary of State, Certificate of Incorporation or Certificate of Organization.
2. Notarized Affidavit of Personal Identification
3. Copy of photo ID that was shown to the notary public

Relocation (physical)
1. Copy of Business license from your local city or 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.
2. Notarized Affidavit of Personal Identification
3. Copy of photo ID that was shown to the notary public

Change in Service (add)
1. Notarized Affidavit of Personal Identification
2. Copy of photo ID that was shown to the notary public
3. Notarized Affidavit of Compliance **(select Private Home Care Providers)**

Change in Service (remove)
1. Notarized Affidavit of Personal Identification
2. Copy of photo ID that was shown to the notary public
3. Notarized Affidavit of Compliance **(select Private Home Care Providers)**

GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Brian P. Kemp, Governor **Dean Burke, MD, Commissioner**

2 Martin Luther King Jr. Dr. SE 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:

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: