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 timeframe 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/.

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 ASTC Regulations, surveys, plan of corrections, permits, facility letters, administrator and/or contact information updates, i.e., email address, phone numbers, email the Acute Care Team at 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. 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. Certificate of Need (CON), Letter of Determination or Letter of Non-Reviewability from the Department of Community Health, Office of Health Planning (DCH OHP). For more information, visit DCH OHP website at https://dch.georgia.gov/con-applications-and-forms .
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. Complete the electronic Owner Form. List all individual owners if applicable. This form must be signed and dated by the owner or the owner's representative.
10. Building Certificate of Occupancy from city or county government
11. Georgia State Fire Safety Inspection or Certificate of Occupancy (Required for Medicaid and Medicare billing). Otherwise, provide approval by the appropriate fire safety authority (**inspection must be dated within 12 months of application submission date**).

Please submit the underlined federal forms directly to the program: hfrd.acute@dch.ga.gov
12. CMS 370 Health Insurance Benefits Agreement
13. CMS 377 Ambulatory Surgical Center Request for Certification in Medicare
14. Licensure fee - see Schedule of Licensure Activity Fees
https://dch.georgia.gov/divisionsoffices/hfrd/hfrd-payment-portal

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). For more information, visit DCH OHP website at https://dch.georgia.gov/con-applications-and-forms .
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. Complete the electronic Owner Form. List all individual owners if applicable. This form must be signed and dated by the owner or the owner's representative.

Please submit the underlined federal forms directly to the program: hfrd.acute@dch.ga.gov
7. CMS 370 Health Insurance Benefits Agreement
8. CMS 377 Ambulatory Surgical Center Request for Certification in Medicare

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 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.

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). For more information, visit DCH OHP website at https://dch.georgia.gov/con-applications-and-forms .
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. Building Certificate of Occupancy from city or county government
7. Georgia State Fire Safety Inspection or Certificate of Occupancy (Required for Medicaid and Medicare billing). Otherwise, provide approval by the appropriate fire safety authority (**inspection must be dated within 12 months of application submission date**).

Please submit the underlined federal forms directly to the program: hfrd.acute@dch.ga.gov

8. CMS 377 Ambulatory Surgical Center Request for Certification in Medicare
9. CMS 370 Health Insurance Benefits Agreement

Change in Service (add)

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. Please indicate in the letter if construction is being completed.

Change in Service (remove)

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 that is being 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: