GEORGIA DEPARTMENT OF
COMMUNITY HEALTH
David A. Cook., Commissioner

Nathan Deal, Governor

2 Peachtree Street, NW
Atlanta, GA 30303-3159
www.dch.georgia,gov

HEALTHCARE FACILITY REGULATION DIVISION

RE: Relocation of Ambulatory Surgical Centers (State Licensure)

This letter will provide information regarding the relocation of your Ambulatory Surgical Center (ASC). This Section is responsible for licensing ASCs under State Law and assisting the Centers for Medicare and Medicaid Services in performing the certification function for those providers wishing to participate in the Medicare program.

STATE LICENSURE APPLICATION REQUIREMENTS:
Before this Section can survey your facility for a license to operate an ASC at the new location, you must submit the following documents:

1. **A completed application to operate an ASC.**
2. **A copy of the CON or LNR (Letter of Non-Reviewability) authorizing the relocation.**
3. **A copy of the construction plan approval and final inspection and occupancy letters issued by the state architect.**
4. **A copy of the fire safety authority (city, county, or state) inspection report which states an inspection has been made of the premises and that state and local fire safety requirements have been met.**
5. **Copy of the certificate of occupancy for the ASC.**

STATE LICENSURE SURVEY:
Please mail the completed application and the CON or LNR to the attention of the Program Director of the Acute Care Unit at 2 Peachtree St., NW, Suite 31-447, Atlanta, Georgia 30303-3142 as soon as possible. The remaining required documents may be faxed to 404-657-8934. As soon as you can determine a date when the center will be ready, please contact this office to make arrangements for your licensure survey. The survey process consists of a tour of your facility to ensure that all preparations are complete and the center is ready to receive its first patient. Surgery may not be performed at the new location until the licensure survey is completed and any deficiencies found corrected.

ISSUANCE OF A PERMIT NUMBER:
At the conclusion of the survey, if your facility has been found to be in full compliance with the Rules and Regulations for Ambulatory Surgical Treatment Centers (Chapter 290-5-33), your permit will be issued effective the last day of the survey. If deficiencies are cited, your permit will be issued effective the date this Section receives an acceptable plan of correction.

Under State law and regulations, you must notify this Section at least 30 days in advance of any change in ownership. The State Permit is not transferable.

MEDICARE APPLICATION REQUIREMENTS:
If your ASC is also Medicare certified, in order to make the relocation change with Medicare, two forms must be completed. You must submit a completed Form CMS-377 noting all information for the new ASC location. This form should be mailed with the State application.

Second, you must provide the Medicare Administrative Contractor (Carrier) with an updated supplier enrollment application (855B form). Supplier enrollment applications (855B forms) are available for downloading at http://www.cms.hhs.gov/CMSforms/downloads/cms855b.pdf along with a user's guide providing instructions for completing the forms. The Carrier for Georgia is Cahaba Government Benefits Administrators, LLC. The supplier enrollment application (855B) must be submitted directly to Cahaba GBA, Attn: Georgia Provider Enrollment, P.O. Box 12967, Birmingham, AL 35202. The Carrier can be reached by calling Provider Enrollment at 1-866-582-3246. If you require help or assistance in completing the CMS 855B form, contact the Carrier, not the Healthcare Facility Regulation Division (HFRD). The Carrier will notify HFRD of its recommendation for approval or denial of enrollment for your ASC. HFRD cannot complete the change in location with Medicare until the Carrier approves your enrollment application (855B) and HFRD is notified.

If we can be of further assistance to you, please contact the Acute Care Unit Program Director at (404) 657-5449.

ENCLOSURES:
License Application
Form CMS-377

DEPARTMENT OF COMMUNITY HEALTH
HEALTHCARE FACILITY REGULATION DIVISION
ACUTE CARE SECTION
2 PEACHTREE STREET NW, SUITE 31-447
ATLANTA, GEORGIA 30303-3142

APPLICATION FOR A PERMIT TO OPERATE AN AMBULATORY SURGICAL TREATMENT CENTER

Pursuant to O.C.G.A. 31-7-1 et seq. Application is hereby made to operate the Ambulatory Surgical Center which is identified as follows:

SECTION A - IDENTIFICATION

Date of application: _____ Type of application: ☐ Initial ☐ Change of Ownership ☐ Address ☐ Name
☐ Scope of Services ☐ Other_____

Name of Ambulatory Surgical Center (This name will appear on Permit)

Address_____City_____ County_____Zip+4 _____

Phone: (_____)_____ - _____ FAX: (_____)_____ - _____ E-Mail Address: _____

_____
Official Name and Address of ASTC Governing Body

_____
Name of Person Delegated Responsibility for Day-to-Day Management/Administration of ASTC (regulation 290-5-35-.03 (5)

_____ Title: _____

Agent for Service/Legal Representative name: _____

Complete Address of Agent for Service/Legal Representative

Classification (check one)
☐ Single or Multi-Specialty (Certificate of Need required)
☐ Physician Owned Single Specialty (Letter of Nonreviewability required)

List Type and Scope of Surgical Services (refer to regulation 290-5-33-. 04)

_____

_____

Number of Operating Rooms	Number of Minor Procedure Rooms	Patient Capacity of Recovery Rooms
_____	_____	_____

Days and Hours ASTC Open

Days and Hours Surgery Performed

_____

SECTION B – STAFF

List Names, Addresses, and Specialty of Professional Director and Other Physicians on the Medical Staff

Professional Director: _____

Other Physicians on the Medical Staff: _____

_____

_____

_____

SECTION C – PROVISIONS FOR CARE

List All Health Care Providers with whom the Center has Arrangements/Contracts (specify services)

Name	Service

SECTION D – OWNERSHIP INFORMATION

Type of Ownership

☐ Individual ☐ Partnership ☐ Corporation ☐ Other (specify)_____

1. List Names and Addresses of All Owners with 5% or More Interest (refer to regulation 290-5-33-.03 (2)

_____

_____

_____

2. Centers Organized as a Corporation or Partnership – List Names and Addresses of Officers of the Corporation or Principle Partners

_____

_____

_____

SECTION E – CERTIFICATION

I certify that this Facility is devoted primarily to the provision of **SURGICAL** treatment to patients not requiring hospitalization and that this facility will operate in accordance with the rules and regulations governing ambulatory surgical treatment centers. I further certify that the information provided in connection with this application is true to the best of my knowledge and belief. (Refer to regulation 290-5-33-.01 (A)

_____

Signature of Principal Officer of Governing Board Title Date

_____

(For Department Of Community Health Use Only)

_____ _____

Date Received Center Permit Number

_____ _____

Reviewed by Effective Date

Fire Safety Statement Attached: ☐ Yes ☐ No

_____

Approved Date

Copy of CON or LNR Attached: ☐ Yes ☐ No

INSTRUCTIONS FOR COMPLETING AFFIDAVIT
REQUIRED TO BECOME LICENSED

In order to obtain a license from the Department of Community Health to operate your business, Georgia law requires every applicant to complete an affidavit (sworn written statement) before a Notary Public that establishes that you are lawfully present in the United States of America. This affidavit is a material part of your application and must be completed truthfully. Your application for licensure may be denied or your license may be revoked by the Department if it determines that you have made a material misstatement of fact in connection with your application to become licensed. If a corporation will be serving as the governing body of the licensed business, the individual who signs the application on behalf of the corporation is required to complete the affidavit. Please follow the instructions listed below.

1. **Review the list of Secure and Verifiable Documents under O.C.G.A. §50-36-2 which follows these instructions. This list contains a number of identification sources to choose from that are considered secure and verifiable that you can use to establish your identity, such as a U.S. driver's license or a U.S. passport. Locate one original document on the list to bring to the Notary Public to establish your identity.**

2. **Print out the affidavit. (If you do not have access to a printer, you can go to your local library or an office supply store to print out the document for a small fee.)**

3. **Fill in the blanks on the Affidavit above the signature line only—<u>BUT DO NOT SIGN THE AFFIDAVIT at this time.</u> (You will sign the affidavit in front of the Notary Public.) Fill in the name of the secure and verifiable document (for example, Georgia driver's license, U.S. passport) that you will be presenting to the Notary Public as proof of your identity. <u>CAUTION: Put your initials in front of only ONE of the choices listed on the affidavit and described here below:</u>**

   - **Option 1) is to be initialed by you if you are a United States citizen; or**

   - **Option 2) is to be initialed by you if you are a legal permanent resident of the United States. You are not a U.S. citizen but you have a green card; or**

   - **Option 3) is to be initialed by you if you are a qualified alien or non-immigrant (but not a U.S. citizen or a legal permanent resident) with an alien number issued by the Department of Homeland Security or other federal immigration agency. Fill in the alien number, as well.**

4. **Find a Notary Public in your area. Check the yellow pages, the internet or with a local business, such as a bank.**

5. **Bring your affidavit and the identification you selected (from the list of Secure and Verifiable Documents) to appear before the Notary Public.**

6. **Show the Notary Public your secure and verifiable identification (anything on List that follows these instructions) and state under oath in the presence of the Notary Public that you are who you say you are and that you are in the United States lawfully. Then sign your name.**

7. **Make certain that the Notary Public signs and dates the affidavit and puts when the notary commission expires.**

8. **Make a copy of the affidavit and the identification that you presented to the Notary Public for your own records.**

9. **Attach the ORIGINAL SIGNED AFFIDAVIT and a copy of the identification you presented to your application for licensure. DO NOT SEND US YOUR AFFIDAVIT SEPARATELY. IT MUST BE INCLUDED IN THE COMPLETE APPLICATION PACKET WHICH YOU <u>MAIL</u> TO US.**

Secure and Verifiable Documents Under O.C.G.A. § 50-36-2

Issued August 1, 2011 by the Office of the Attorney General, Georgia

The Illegal Immigration Reform and Enforcement Act of 2011 ("IIREA") provides that "[n]ot later than August 1, 2011, the Attorney General shall provide and make public on the Department of Law's website a list of acceptable secure and verifiable documents. The list shall be reviewed and updated annually by the Attorney General." O.C.G.A. § 50-36-2(f). The Attorney General may modify this list on a more frequent basis, if necessary.

The following list of secure and verifiable documents, published under the authority of O.C.G. A. § 50-36-2, contains documents that are verifiable for identification purposes, and documents on this may not necessarily be indicative of residency or immigration status.

- A United States passport or passport card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A United States military identification card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A driver's license issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- An identification card issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A tribal identification card of a federally recognized Native American tribe, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer. A listing of federally recognized Native American tribes may be found at: http://www.bia.gov/WhoWeAre/BIA/OIS/TribalGovernmentServices/TribalDirectory/ind/ex.htm [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A United States Permanent Resident Card or Alien Registration Receipt Card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- An Employment Authorization Document that contains a photograph of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A passport issued by a foreign government [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

- A Merchant Mariner Document or Merchant Mariner Credential issued by the United States Coast Guard [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

- A Free and Secure Trade (FAST) card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]

- A NEXUS card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]

- A Secure Electronic Network for Travelers Rapid Inspection (SENTRI) card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]

- A driver's license issued by a Canadian government authority [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

- A Certificate of Citizenship issued by the United Stated Department of Citizenship and Immigration Services (USCIS) (Form N-560 or Form N-561) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

- A Certificate of Naturalization issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-550 or Form N-570) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

- In addition to the documents listed herein, if, in administering a public benefit or program, an agency is required by federal law to accept a document or other form of identification for proof of or documentation of identity, that document or other form of identification will be deemed a secure and verifiable document solely for that particular program or administration of that particular public benefit. [O.C.G.A. § 50-36-2(c)]

O.C.G.A. § 50-36-1(e)(2) 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(e)(1), 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:

FORM APPROVED
OMB NO 0938-0266

AMBULATORY SURGICAL CENTER REQUEST FOR CERTIFICATION IN THE MEDICARE PROGRAM

(Please see statement on reverse and read the following instructions before completing this form)

Submission of this form will initiate the process of obtaining a decision as to whether the Conditions of Coverage are met. Assistance in completing the form is available from the State agency.

Answer all questions as of the currrent date. Return the original and first two copies to the State agency; retain the last copy for your files. If a return envelope is not provided, the name and address of the State agency may be obtained from the nearest Social Security Office.

Detailed instructions are given for questions other than those considered self-explanatory.

Medicare Supplier Number - Insert the facility's six-digit supplier number. Leave blank on initial requests for certification.

Related Provider Number - Complete this block when a facility is participating under more than one provider number, such as a facility also participating as a hospital. The number in this block for each related provider will be the provider number of the highest level of care.

NOTE: If an ASC is operated by a hospital, has a Distinct Part SNF, ICF and ICF/MR, the related provided number field on the application for each provider (including the hospital) will have the hospital provider number.

State/County and State Region Codes - Leave blank. The Centers for Medicare & Medicaid Services Regional Office will complete.

Item III - If a service is provided directly by the facility, place a '1' in the appropriate block. If a service is provided through an outside source (i.e., by contract or referral), place a '2' in the appropriate block.

Item IV - 'X' the appropriate blocks representing categories of surgery offered by the ASC. Under "Other," include only broad categories (i.e., not subspecialties).

Medicare Supplier Number AS1	Related Provider Number AS2	State/County Code AS3	State Region Code AS4	Fiscal Year Ending Date AS5
I IDENTIFYING INFORMATION	Name of Facility		Street Address	
	City, County, and State		Zip Code	Telephone No. (Include Area Code) AS6
II TYPE OF CONTROL (x one box) AS7	1. ☐ Proprietary	2. ☐ Non-Profit	3. ☐ Government	
III ANCILLARY SERVICES (Place '1' or '2' in blocks) AS8	1. ☐ Laboratory	2. ☐ Radiology	3. ☐ EKG	4. ☐ Pharmacy
IV SURGICAL SPECIALTIES (X appropriate blocks) AS9	1. ☐ Cardiovascular 2. ☐ Foot 3. ☐ General 4. ☐ Neurological 5. ☐ Obstetrics/Gynecology	6. ☐ Ophthalmology 7. ☐ Oral 8. ☐ Orthopedic 9. ☐ Otolaryngology 10. ☐ Plastic	11. ☐ Thoracic 12. ☐ Urology 13. ☐ Other (Specify) _____	
V FACILITY CHARACTERISTICS	1. Number of Operating Rooms _____ AS10		2. Date Center Began Providing Services _____ AS11	

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION ON THIS STATEMENT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OR A REQUEST TO PARTICIPATE OR, WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY OR THE SECRETARY, AS APPROPRIATE.

Signature of Authorized Official (sign in ink)	Title	Date AS12

According to the Paperwork Reduction of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0266. The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, searching existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimates(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

FORM APPROVED
OMB No. 0938-0266

HEALTH INSURANCE BENEFITS AGREEMENT

(AGREEMENT WITH AMBULATORY SURGICAL CENTER PURSUANT TO SECTION 1832(a)(2)(F) OF THE SOCIAL SECURITY ACT)

For the purpose of establishing eligibility for payment under title XVIII of the Social Security Act,

_____

(Insert Name of Facility)

hereinafter referred to as the Ambulatory Surgical Center, hereby agrees:

(A) to maintain compliance with the conditions set forth in part 416 of chapter IV, title 42 of the Code of Federal Regulations, and to report promptly to the Centers for Medicare & Medicaid Services (CMS) any failure to do so;

(B) not to charge a Medicare beneficiary or any other person for items or services for which the beneficiary is entitled to have payment made in accordance with part 416 of chapter IV, title 42 of the Code of Federal Regulations;

(C) to refund as promptly as possible any money incorrectly collected from beneficiaries or from someone on his or her behalf;

(D) to furnish to CMS, if requested, information necessary to establish payment rates specified in §416.120 and §416.130 in the form and manner that CMS requires;

(E) to accept assignment for all facility services furnished in connection with covered surgical procedures as specified in §416.85; and

(F) to comply with statutory and regulatory requirements regarding revision of the Quality Improvement Organization that contracts with CMS to review ambulatory surgical procedures.

This agreement, upon submission by the Ambulatory Surgical Center and upon acceptance for filing by the Secretary of Health and Human Services, shall be binding on the Ambulatory Surgical Center and the Secretary. The agreement may be terminated by either party in accordance with regulations. In the event of termination, payment will not be available for Ambulatory Surgical Center services furnished on or after the effective date of termination.

This agreement shall become effective on the date specified below by the Secretary or the Secretary's delegate, and shall remain in effect unless terminated. In the event of a transfer of ownership of the Ambulatory Surgical Center, **this Agreement Shall Remain Effective** as between the Secretary of Health and Human Services and the Transferee.

ATTENTION: Read the following provision of Federal law carefully before signing.

Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or make any false, fictitious or fraudulent statement or representation, or makes or uses any false writing or document knowing the same to contain any false, fictitious or fraudulent statement, or entry, shall be fined not more than $10,000 or imprisoned not more than 5 years or both (18 U.S.C. section 1001).

Accepted for the Ambulatory Surgical Center by:	Accepted for the Secretary of Health and Human Services by:
NAME (SIGNATURE)	NAME (SIGNATURE)
TITLE	TITLE
DATE	DATE

EFFECTIVE DATE OF AGREEMENT

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0266. The time required to complete this information collection is estimated to average 5 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland 21244-1850.