

INSTRUCTIONS FOR COMPLETING AN APPLICATION FOR A LICENSE TO OPERATE A DRUG ABUSE TREATMENT AND EDUCATION PROGRAM

No governing body shall operate a drug abuse treatment and education program in the state without first obtaining a license or provisional license-290-4.2.05. Completion and submission of the application form is required-290-4-2.07.

For specific definitions, procedures and requirements refer to the regulations (290-4-2). Answer all questions as of the date of application. If a significant change is anticipated please note and attach an explanation. Fill in all applicable blanks. Return the original to the Health Care Facility Regulation (HFRD-address at top of application). For any substantial delay in completing this form or questions contact HFRD, Specialized Care Unit at 404-657-5411.

DETAILED INSTRUCTIONS READ BEFORE COMPLETING APPLICATION

Section A. Identification

Type of Application (Check or complete all that apply):

Initial— first application for this program.

Renewal—a new application is required prior to each renewal survey.

Update/Change of Status—licenses are non-transferable for a change of location or governing body and must be returned to HFRD. Please describe changes (i.e. location, governing body, name of program, program modality). Attach additional information if necessary.

Parent/Subunits/Branches—if a program has Subunits or Branches (see Section C of these instructions and the rules for definitions), check Parent and fill in number of Subunits and/or Branches. Otherwise leave blank.

Accreditation status (optional): Include expiration date of current accreditation and type of accreditation.

Name of Program: Official name of the Drug Abuse Treatment and Education Program at this location. If part of a system or services, begin name with the name of the system.

Phone: Number including area code. Include fax number if available.

Street Address (where services provided): Include city, county and zip code. Complete on application only for each location/street address where treatment and education subject to licensure are provided. Branch (part-time) programs must complete a separate application (attach to parent's application) but must be licensed under the permit of a full-time program.

Program mailing address: Specify address where official mail is to be sent to the administrator of the program.

E-mail address: Include if correspondence is acceptable by e-mail.

Official Name of Governing Body: Official name of individual or organization that owns or is responsible for the program. CSB programs enter the official name of CSB.

Address of Governing Body: Location and mailing address of the Governing Body.

Administrator (appointed by Governing Body): Must be officially appointed by the governing body. Include title if different than Administrator (i.e. CEO).

Clinical Director: A licensed physician, licensed practitioner or a certified addiction counselor appointed by the governing body and responsible for all treatment provided.

On-site manager: The on-site clinician designated responsibility for the drug treatment and education provided at this location.

Section B. Ownership Information—Type of Ownership

Specify the type of legal ownership of the program by checking the applicable spaces. If other than the categories provided, check "other" and explain. Initial applications must include a copy of business license, IRS business tax identification number, proof of identity, certificate of occupancy, and for corporations a copy of the certification of incorporation.

Section C. Program Modalities Provided (check all located at program address)

Check all of the types of programs (as defined by the regulations) provided at the program's street address (section A).

Residential programs must specify the number of Transitional, Intensive, and Sub-acute Detox beds and whether the program provides food service (or it is contracted).

A Subunit is a separately licensed full-time program that is part of an organization with a designated main facility or Parent program.

A Branch is a part-time outpatient program (without the capacity to provide a drug abuse intake assessment and physical assessment at least 40 hours per week) that is part of a regional organization that includes a full-time licensed program. A Branch is licensed as a part of the full-time main licensed facility of an organization (Parent). Subunits and Branches must include the name and license number of the Parent program in the space provided. If a program offers special services for pregnant females check maternity and indicate approximate number of maternity clients.

Section C. (continued)- ASAM Patient Placement Criteria

Check all of the ASAM Placement types (as defined by the regulations) provided at the program's street address (section A).

Section D. Personnel (assigned to program address section A)

After each category record the number of staff scheduled to provide drug treatment and education at this location either full-time or part-time. If more than one type of program exists at this location, you can combine staff data or attached additional staffing information. Full-time is considered at least 40 hours per week. Total hrs/wk—record the total hours each week for each category of staff on-site. For personnel not listed, write in title/profession (i.e. Physician) after "Consultants" for "Other" and enter full-time or part-time information and total hours on-site. Enter the name of the physician who oversees all medical services provided by the program in the space provided after Medical Director. This person may or may not be full-time or part-time at this site.

Section E. Program Information for services provided at this location

Answer questions regarding the drug abuse treatment and education provided at the program address section A. For new programs (not yet in operation) enter the planned level of services and note "planned". Part-time programs affiliated with a full-time program will be classified as a Branch but must complete the application form.

Section F. Required Attachments per O.C.G.A. Sections 26-5-8 and 50-36-1

Comprehensive Program Outline (include ASAM level/s provided at this location). A description of the drug abuse treatment and education provided at this location and a copy of all required policies and procedures.

Proof of compliance with laws for the handling and dispensing of drugs. Copies of appropriate policies approved by the governing body are acceptable.

Proof of compliance with applicable state and local health, safety, sanitation, building and zoning codes. Copies of recent inspections by appropriate local or state authorities.

New or relocated programs also must attach Certificate of Occupancy.

Affidavit of Applicant verifying lawful presence in the United States.

Section G. Certification Signature of Principal Officer of Governing Body or their designee and date signed. Printed Name of Principal Official designee that signed form and title.

HEALTHCARE FACILITY REGULATION DIVISION
SPECIALIZED CARE SECTION
2 PEACHTREE STREET N.W.
SUITE 31.447
ATLANTA, GA 30303-3142

APPLICATION FOR A LICENSE TO OPERATE A DRUG ABUSE TREATMENT AND EDUCATION PROGRAM

Pursuant to provision of O.C.G.A.26-5-1 et seq. Application is hereby made to operate the Drug Abuse Treatment and Education Program which is identified as follows (separate application required for each program location subject to licensure): *** Effective August 3, 2010, a fee must be paid for each new application, change of ownership, change of location, or renewal of license. Before you apply for any new application or changes, please download the payment coupon and submit the correct payment to the mailbox on the coupon form. Then, please follow the directions for the application below.**

Section A. Identification

Type of Application: Initial _____ Renewal _____ Update/Change of status(explain): _____

Parent: _____ Sub-units (#) _____ Branches (#) _____ (sep. applications required- attach)

Accreditation Status: (optional) Expiration date _____ Type: _____

Name of Program _____ Phone _____

Program Street Address (where services provided) _____ City _____ County _____ Zip Code _____

List addresses of all residential sites, including apartment numbers _____

Program Mailing Address _____ E-mail Address _____

Official Name of Governing Body _____

Administrator (appointed by Governing Body) _____ Clinical Director _____ On-site Manager _____

Section B. Ownership Information – Type of Ownership

Proprietary Profit _____ Individual _____ Partnership _____ Corporation (include copy of certificate of incorporation) _____ Other (specify) _____	Non-Profit _____ State _____ County _____ City _____ Hospital Authority	_____ Community Service Board _____ Church _____ Corporation _____ Other (specify) _____
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List names and addresses of all owners above with five percent (5%) or more interest, or officers of a corporation or partners of a partnership, as applicable (attach additional sheets if necessary)

Section C. Programs Modalities Provided (check all located at program address section A)

Outpatient _____ Amb. Detox _____ Specialized Day Treatment _____

Residential Beds: Transitional (#) _____ Intensive (#) _____ Detox _____ w food service _____

Subunit _____ Branch (part time, a part of a full-time licensed program) _____

Parent name and license # _____
(required for subunits and branches)

Populations served: male _____ female _____ Maternity (approx #) _____
adult _____ adolescent _____ children _____ age range _____

Special Program (explain) _____

Section C. (continued)- ASAM Patient Placement Criteria

I	Outpatient services	_____	III-2-D (circle one)	Clinically-managed residential detox	_____
II.1	Intensive outpatient	_____		Residential Subacute	_____
II.5 (circle one)	Partial hospitalization	_____		Ambulatory Detox	_____
	Specialized Day Treatment and Outpatient	_____	III.3 (circle one)	Clinically-managed medium intensity residential	_____
II-D	Ambulatory detox w/ extended on-site monitoring	_____		Residential Intensity	_____
III. 1 (circle one)	Clinically-managed low intensity residential	_____	III.5 (circle one)	Clinically-managed med/high intensity residential	_____
	Residential Transitional	_____		Residential Intensity	_____

Section D. Personnel (assigned to program address section A)

	# full-time	# part-time	total hrs/wk
Counselor / Therapist / Social Worker (certified or licensed)	_____	_____	_____
Counselor (not certified or licensed)	_____	_____	_____
Consultants (specify type) _____	_____	_____	_____
Registered Nurses	_____	_____	_____
Licensed Practical Nurses	_____	_____	_____
Administrative Personnel	_____	_____	_____
Medical Director (name) _____	_____	_____	_____
Other (specify) _____	_____	_____	_____

Section D. Personnel (assigned to program address section A)

Number of hours each week that Drug Treatment & Education Services are scheduled: _____

Hours each week that a physician, physician's assistant or nurse scheduled to be present: _____

Specific days/hours of operation for the provision of Drug Treatment & Education: _____

Minimum number of program staff present during operating hours: _____

Current number of active Drug Treatment & Education Clients: _____

Services other than Drug Treatment & Education provided at this location: _____

Section F. Required Attachments

- Comprehensive Program Outline (include ASAM level/s included at this location)
- Proof of compliance with laws for the handling and dispensing of drugs
- Proof of compliance with applicable state & local health, safety, sanitation, building & zoning codes
- Affidavit of Lawful Presence in United States

Section G: Certification

I certify that this facility will comply with the Rules and Regulations for Drug Treatment & Education Programs. I understand that a license is non-transferable and must be returned to the Healthcare Facility Regulation Division if a program closes, changes location or governing body. I certify that the above information is true to the best of my knowledge.

Signature of Principle Officer of Governing Body or Authorized Representative _____ Date of Signature _____

Printed Name of Principle Officer of Governing Body or Authorized Representative _____ Title _____

FOR STATE USE ONLY

Date Received: _____ Reviewed by: _____

Approved as: _____ Effective Dates: _____

Section / Unit Director Approval / Comments: _____

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—BUT DO NOT SIGN THE AFFIDAVIT at this time. (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. CAUTION: Put your initials in front of only ONE of the choices listed on the affidavit and described here below:**
 - 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 MAIL 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 States 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: